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## MEDICINE



JULY 1993 VOL. 92, NO. 7

Award-Winning Journal of the Michigan State Medical Society



Cover

#### Technology In Medicine

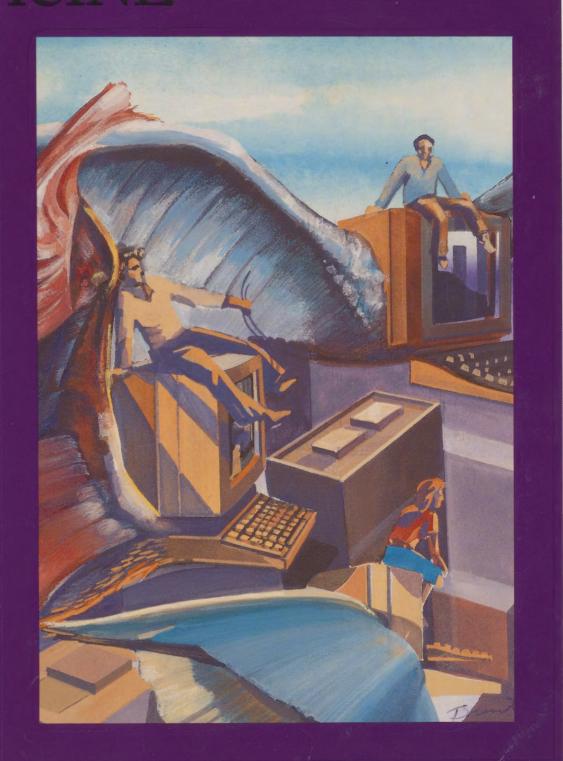
Caring for the Dying Patient A Profile of John W. Finn, MD

#### Focusing on Finances

National Coalition of Physicians Against Family Violence

#### Also included:

- MSMS on the Move
- Legal Briefs
- President's Page



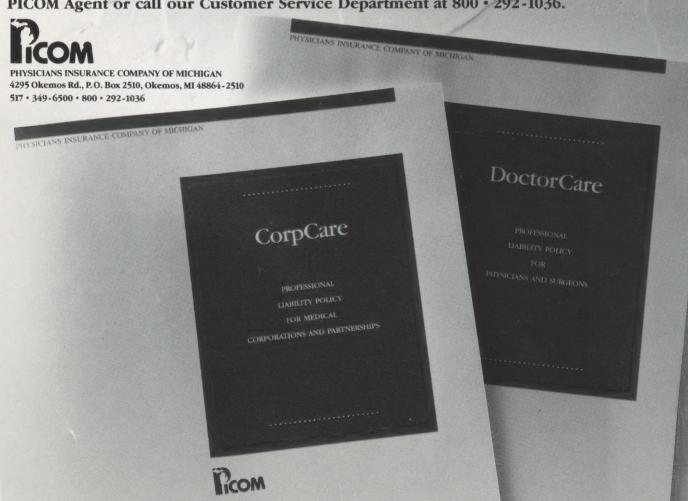
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#### MICHIGAN MEDICINE

**JULY 1993** 

VOLUME 92, NO. 7

Award-Winning Journal of the Michigan State Medical Society

#### **COVER STORY**

When MSMS conducted a series of focus groups last fall as part of its "Medicine in the Year 2002" project, no topic captured as much excitement as did computerization and its impact on the physician's office by the year 2002. This month's cover story begins with an indepth narrative by one physician on how he survives healthcare of the 90s with his computer. Also included in this month's cover story is an article by an MSMS-selected practice management consultant on "Electronic Billing: The Beginning Step." Rounding out the cover story is the list of physicians who are serving on the recently-established MSMS Committee on Technology in Medicine.



#### **OTHER KEY ARTICLES**

#### 22

#### **Medicine People**

An indepth profile of John W. Finn, MD, medical director of Hospice of South Eastern Michigan, who says that "Caring for the dying is a privilege." By Helen Fordham

#### 27

#### A Wake Up Call for Physicians

In this feature, the president and CEO of Michigan Physicians Mutual Liability Company explains why it's time for physicians to focus on finances. By Thomas R. Berglund, MD

#### 31

#### National Coalition of Physicians Against Family Violence

More than 180 Michigan physicians, alliance members, and professionals have joined this campaign against family violence.

#### 35

#### **Legal Briefs**

MSMS legal counsel explains the Michigan Limited Liability Company, a new structure for medical practice.

By James R. Cambridge

#### 38

#### **Board of Medicine Actions**

#### DEPARTMENTS

- 7 MSMS ON THE MOVE
- 42 DEATHS
- 44 MEETINGS
- 47 CATEGORY I COURSES
- 53 CLASSIFIED ADVERTISING
- 55 ADVERTISING INDEX
- 56 PRESIDENT'S PAGE

#### in next month's issue:

1993 MSMS House of Delegates Proceedings

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

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The Michigan State Medical Society Committee on Publications is the editorial board of Michigan Medicine and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

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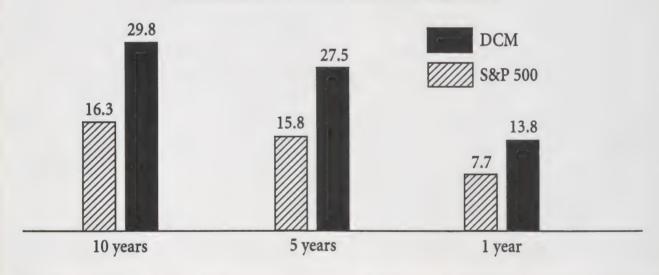
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## MSMS ON THE MOVE

#### A monthly update of key MSMS activities



MSMS "Doctor of the Day" program connects physicians with legislators

Today, physician involvement in the political arena has become a necessity. That's because doctors must speak up on the numerous bills and regulations proposed and passed that would affect practices. It's also because legislative reforms desperately needed in the nation's health care system cannot and should not be made without input from a key part of that system—physicians.

To help doctors learn more about the political process so that they can get involved, MSMS has developed the Doctor of the Day Program. It gives doctors a chance to observe the Michigan political process and talk directly to legislators.

The Doctor of the Day Program also is part of a larger MSMS Physician Legislative Network. MSMS has created that network to build a base of physician grassroots support for issues such as medical liability reform. If you'd like to take part in the Doctor of the Day Program and/or the Physician Legislative Network, call Greg Aronin at (517) 336-5739.

**MSMS** fax network gets information to doctors quickly

MSMS is building a fax network. It's a data base of physician fax numbers so that MSMS can reach physicians quickly with information on legislative alerts, educational seminars and physician services. Join our network by faxing your fax number to MSMS at (517) 337-2490.

New MSMS division helps with POs/PHOs MSMS has started a new division, Management and Organization Services (MOS), to provide physicians expert consultant help in forming physician organizations (POs) and physician-hospital organizations (PHOs). MOS has selected attorneys, certified public accountants, business and tax advisors, strategic planners and others to help doctors meet the challenges of a changing health care environment. For details, or to request services, call John Richards at (517) 336-7570.

POS/PHOS focus of MSMS summer seminars, fall conference Doctors also can learn more about creating POs and PHOs by attending an MSMS seminar in their area in July or August. They're coming up:

- July 13/Detroit (afternoon)
- July 21/Traverse City (afternoon)
- July 23/Marquette (afternoon)
- July 27/Flint (evening)
- August 4/Kalamazoo (afternoon)
- August 11/Ann Arbor (afternoon)
- August 17/Saginaw (afternoon)
- August 26/Troy (evening)

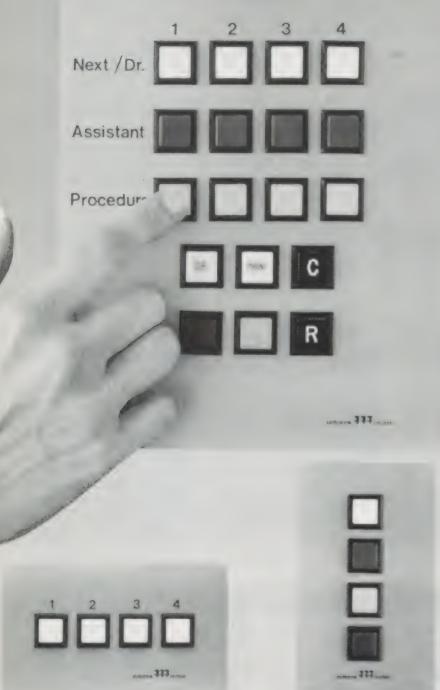
\*Afternoon sessions 1:00 pm - 4:30 pm Evening sessions 5:30 pm - 9:00 pm

336-5724, or Tom Wolff at (517) 336-5740, for more information.

Call the MSMS Office of Physician Education at (517) 336-5784 for details. MSMS also plans a fall conference on POs and PHOs Sept. 10-11 at the Embassy Suites hotel in Southfield. Physicians will be invited to attend and bring with them hospital administrators and board members. Call Tom Plasman at (517)

For details on these and other issues call William E. Madigan, Executive Director, MSMS 517/337-1351.

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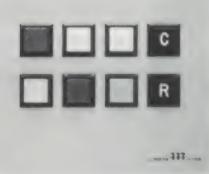
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Cover Story

#### TECHNOLOGY IN MEDICINE

hen MSMS conducted a series of focus groups last fall as part of its "Medicine in the Year 2002" project, no topic captured as much excitement as did computerization and its impact on the physician's office by the year 2002. "The capabilities are astounding in billing and patient records and other areas peripheral to the patient contact," said one of the focus group participants. Said another: "I can see histories and physicals and lab tests going into a computer, the computer actually picking out key words and firing back diagnostic possibilities."

This month's cover story begins with an indepth narrative by one physician on how he survives healthcare of the 90s with his computer. The physician is Edmund Messina, MD, an Owosso neurologist who is president of both the Shiawassee County Medical Society and Medical Practice Standards, Inc. The author of many commercial software programs, he is a member of the recently-established MSMS Committee on Technology in Medicine.

Also included in this month's cover story is an article by an MSMS-selected practice management consultant on "Electronic Billing: The Beginning Step."

Rounding out the cover story is the list of physicians who are serving on the recently-established MSMS Committee on Technology in Medicine.

## How | Survive Health Care of the 90s

#### With My Computer

By Edmund Messina, MD



his is the story of a physician (me) who started with a simple programming project and ended up with an ongoing obsession to become more efficient. As crazy as these 12 years have been, I now have the most organized practice around. Here is how it happened.

It started during training. I was the type of chief resident that drove everyone crazy. I had organized the outpatient clinic with rules, protocols and checklists to keep us efficient. When I started practice in Muskegon in the early 1980s, I bought one of the first PC computers and then things got out of hand. I saw the computer as an even more exacting way to keep patient information straight.

As I wrote more programs, I realized that these would be the tools of survival in the future. Before long, I was hiring other programmers and colleagues began investing in the project. Over the years, the programs have emerged and evolved and now I cannot imagine practicing medicine without a PC. I am very proud of my programs and many colleagues around the country share my enthusiasm. Let me show you what I mean.

I have found that
I can see more
patients in a day,
without compromising
the encounter time,
by letting the computer
and my staff handle
the 'busywork.'

#### A typical day at the office

I usually get to the office before my staff, to chip away at the in-basket and start up the computer. This is the opening ritual of the day. I usually look for any special reminders the computer has for the day and generally check what my work load was for the last 30 days (typical paranoid subspecialist). The others begin to arrive. Kathy, the medical assistant, begins to print out worksheets for the patients to be seen on the following day. She checks these printouts to be sure that all tests due on tomorrow's patients have come in. If not, she has the day to chase the results or contact the patients.

By now the RN arrives and the workstations in

each exam room are turned on. They are connected through a local area network (LAN) to our main PC where all the data is stored.

The first return visit patient is ushered to a room and their record is on the screen. The nurse enters their vital signs and a nursing note into the system. This note is based on guidelines set by the computer as it scans their active problem list.

I am the next one to enter the room, armed with the patient summary sheet generated the following day. At a glance, I can see my last progress note, all charted phone conversations with that patient or any mention of missed or rescheduled visits in the interim. I look

at the data the nurse entered under the "S" part of the SOAP note. I push the F3 key and I see all test results that have arrived and we begin our conversation. My patients are used to me quietly typing a few words at a time as we have our visit. Sometimes they like to look over my shoulder to see what I am writing. Some physicians use the same technique; others will wait until the visit is over to dictate the note in private for later transcription.

This is a difficult patient, not responding well to the present

plan. The F2 key shows her current meds and all previous ones, when prescribed and why they were stopped. This takes about two seconds and the plan can be modified accordingly. A new medication is selected, one is stopped and a blood test is ordered with a few quick keystrokes. The process is over. The patient and I chat for a while about the new plan and we part. I am finished with that encounter. If a person wonders about possible medication interactions, I reassure them with a drug interaction program such as the one from Medical Letter or the PDR. I can put it right on the screen to offset any misinformation they

Continued on following page

Continued from page 11

might get from lay publications or the printouts at the local pharmacy.

Meanwhile, the computer is busily processing what I have done. It is writing the new prescriptions and test requests and making the appropriate changes on the patient information sheet. It prints out an updated instruction sheet for the patient with instructions appropriate to the new medication, reviews the other meds and shows what tests were ordered and how to prepare for them. Next, it takes the few sentences that the RN and I have typed into the SOAP note and adds all the other changes made during the visit. It prints out a detailed progress note. with vital signs and all.

During this time, which is seconds, I have walked

over to the printer and I sign each of these documents as they pop out. My encounter is over, well documented and legible and I feel gratified that I was able to spend some good teaching time with the patient.

As I go from room to room in this manner, a new patient is placed in a room. As often happens, I have received no previous medical records on this patient. The RN does the usual initial interview and the patient is asked to answer some automated questions on the computer screen. He presses the keys for the multiple choice

questions and in 20 minutes he is finished. The assistant then prints out the detailed narrative report and leaves it for me.

As I interview the new patient, I review the narrative general medical history, review of systems, family history, etc., and it just takes a few minutes to confirm or correct the printout. Most of my time is spent on the chief complaint. As I interrogate and examine, I enter a medical problem list into the computer. A few keystrokes allow me to order tests, medications, therapy, etc. We say goodbye and I am off to the next room to dictate a detailed report to supplement the thorough, and now corrected, general history.

Almost all of my time is spent face-to-face with the patient. Very little time is spent on paperwork in my office. I have found that I can see more patients in a day, without compromising the encounter time, by

letting the computer and my staff handle the "busy-

#### The phone call

66 Many people are under

the misunderstanding

that a clinical system is just

an add-on to a billing system.

I dispute that statement.

A good clinical management

system has to be a clinical tool

from the ground up, not just a

simple database or word

processor masquerading as an

'electronic medical record.'

In the midst of the busy day, my nurse is also responding to patient phone calls. We do not spend time chasing charts and filing them again. As she takes the call, the nurse has the patient's record right in front of her on the screen. She knows what was said in the last phone note, my last progress note, etc. She types the note as she is speaking with the patient and tells the patient she will be calling back shortly. The printed patient summary sheet is left on my desk.

As I flit from room to room, I check the phone encounters on my desk. The printout contains all pertinent information since the last office visit, as well

> as today's nursing phone note. I jot a few words of disposition and the nurse acts on it.

Test results

Each day, as results arrive at the office, they are reviewed by the RN and quickly entered into the computer. These will later appear on the chart summary that is printed prior to the next visit. Sometimes a grossly abnormal result will arrive and we may choose to act on it sooner. The nurse will print out a summary sheet and leave it on my desk. Information on

the summary is usually adequate to make a decision without chasing down the paper chart.

#### Weekly audits

My wife Jayne, who is an RN and coordinates the clinical part of the office, prints out an audit of any delinquent test results each week. This way, no test slips past us. Any patient who was supposed to have gotten a test, yearly exam, or other study will be identified. We have a very tight practice and we feel that very little can escape our notice.

#### The efficiency factor

Being computerized has made us very efficient. I am seeing about 30 percent more patients per day compared to before we developed this system. My staffing needs have dropped from five full-time people

Continued on page 14

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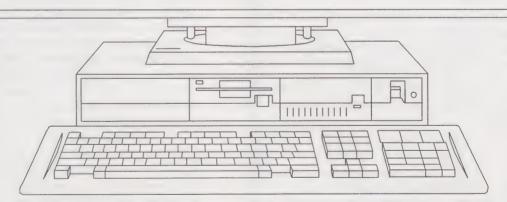
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#### Benefits of Using the Computer as a Clinical Tool

Clinical computing can take many forms, from the automated patient record described here, to other tools such as drug interaction programs, literature search programs, etc. These are just a few reasons to consider adopting a computer into your practice.

- You become very efficient during the patient encounter, so you have a higher daily work output.
- Less time is spent on "busywork" and more time is available for direct patient contact.
- You reduce risks of error by omission. You can meet requirements to make you eligible for merit discounts through your malpractice carrier.
- Patients appreciate "high tech" medicine to assure them that they are getting the latest benefits.
- Programs producing medication instructions can assure patients that their medications are safe or at least show them the aspects of the medications that you want them to know about. Remember, patients are barraged by irresponsible medication information the moment they walk out your door. There are lay books about "bad drugs" and many pharmacies are distributing frightful information sheets and placing instruction labels on your prescriptions, etc., without your knowledge.
- You can create detailed progress notes with less effort to stand up against audits from payors, peer review organizations, etc.
- You can look at your entire practice as a whole if it is in a database, seeking delinquent tests, patients requiring a revisit or identifying patients with specific illnesses or on certain medications.
- You can scan medication lists to look for medication interactions. Several good commercial programs are available.
- You can search medical literature through a modem. There are several good services available.
- You can consult medical texts or references now available on CD-ROM discs, with rapid access and cross reference.
- You can provide patient education.

Continued from page 12

to one full-time and several part-time employees. We still consider the paper chart to be the official medical record but we use it mainly as a place to store the computer's printouts. We spend very little time chasing charts and filing them. Since test results are never lost, we do not duplicate our efforts because of lost data. Because this system fulfills the requirements for merit discounts, we pay six percent less on malpractice premiums. I get by on a fraction of my previous transcription expenses because the computer does so much of the documentation. My charts look good and I get compliments on how well the medical records are organized when HMO auditors come around.

#### Why should physicians computerize their practices?

Just as billing programs have revolutionized the finances of medicine, clinical computing programs have significantly changed they way we practice medicine.

A physician should be aware, however, that many billing systems are good because they are designed by billers. Good clinical systems are designed by clinicians, not financial people. Many people are under the misunderstanding that a clinical system is just an add-on to a billing system. I dispute that statement. A good clinical management system has to be a clinical tool from the ground up, not just a simple database or word processor masquerading as an "electronic medical record."

There is little benefit in having the same system serve both financial and clinical purposes, any more than having a ledger card serve as a patient record. Other than some simple demographics, there is no overlap in the data sets between billing and patient care. Some vendors would lead you to believe that the billing codes should drive the medical problem list, but we all know that the subtleties of medicine go beyond the ICD-9 codes.

I cannot think of a reason not to use a computer in medicine these days. I am constantly working on improving my automated medical record and history-taking tools to meet new challenges such as practice parameters. I am always interested in talking with colleagues with similar needs and interests and I welcome these calls.

Doctor Messina is a practicing neurologist and president of both the Shiawassee County Medical Society and Medical Practice Standards, Inc. He has authored several commercial software programs.

#### **How to Integrate a Clinical Computer into a Medical Practice**

- First, there is no reason to spend much money at the outset. Get into this as a hobby or curiosity and expand from there if you like. Be sure, however, that you do not fall prey to "bargains." Use equipment that has a future, such as the 486 class of PCs. Older machines are on sale but will be obsolete soon. Good computers are getting cheaper by the day and are now sold at a fraction of what a good machine cost us a few years ago.
- Choose your vendors wisely. A "consultant" is usually a salesperson who needs to sell goods or services. If you have any questions, get another opinion. Not all expensive software is good and not all inexpensive software is bad. Talk to your colleagues, or ask your malpractice carrier what they have heard.
- Start simply and accomplish one task at a time. Begin with a single workstation before you go to a network. Do not overreach with large ticket purchases. The PC computer industry is built upon small units. You can always start small and expand.
- Start with a single program such as a drug interaction program, patient database program or history taking program and get your staff familiar with it.
- **Expand in steps to avoid errors.** Once you have mastered the single workstation, consider additional workstations, LANs or local area networks, peer-to-peer networking, etc.
- There are several approaches to adding a patient database program into an already established practice. One way is to take a few thousand charts and enter them into the system. A more practical way is to enter the next day's patients into the sytem until eventually all the active patient base is in the computer.

#### Integrating a clinical computer into a medical practice

People often become paranoid about adding a computer to a medical practice. Some physicians view it as a hopelessly complex tool and they may even think they have to go back to school before they can use it. Office staffs sometimes see this as something that will eliminate their jobs. These are unfounded misconceptions.

In reality, a computer is just another tool, such as a typewriter or copy machine. It is no reason to lose sleep. *There are many good reasons to automate the*  clinical side of medical practice and these become more apparent when you are up and running.

For the sake of this discussion, consider clinical computing programs as programs that do everything but billing or financial operations. These programs include patient database programs, history taking programs, drug interaction programs, literature search programs, etc.

#### Where to begin

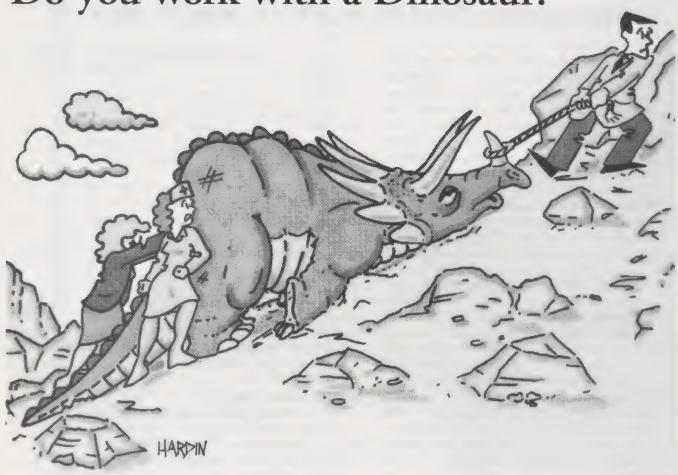
First of all, ask yourself what you want to accomplish. Do you want to use a tool on your desk for a reference tool or integrate it into each patient encounter? Next decide on the type of software you want before you choose a computer. If all you need is an electronic PDR, a palmtop computer would be the best choice. If you want a way to keep the detailed records of all your patients with you at all times, a high end laptop or notebook computer would make the most sense.

#### What type of hardware to buy

The hardware industry is changing by the day and there are many confusing signals to the new buyer or even the experienced user. It is best to purchase the most advanced machine available to avoid obsolescence. It is also best to purchase mainstream type products. Beware of salespeople pushing "mini" computers for a small practice, they will not be around for long. I would recommend that you stay with the more popular PC compatible type machine. In view of the changes occurring in the business today, do not settle for less than a 486 class machine. There are many lesser machines available at very good prices but they may not serve your needs a year from now. All quantity manufacturers are selling these machines for a fraction of what the 386s were costing a couple of years ago. Fortunately, most vendors include Windows in their PC packages and this reduces the learning curve on subsequent programs. It is becoming the industry standard.

Remember, salespeople are now called "computer consultants," but they still have the same objective -to sell as much as possible. Many people get very fine service by just dealing directly with a local computer store. If you know exactly what you need and you do not require a lot of personal support, you can purchase directly through a mail order house. If you choose this option, however, be sure it is a brand that you know.

Do you work with a Dinosaur?



If you've noticed a drag on billing and office management, you may be working with a Dinosaur. Unable to adapt to the rapidly-changing health care landscape, the Dinosaur forces you to rely on old technology and outdated service attitudes. The cost is steep; not just in terms of increased expenses and reduced reimbursements, but in loss of management control, information and potential for growth. Do you work with a Dinosaur? It may be the computer or billing service in your office.

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#### **Electronic Billing:**

It's more than just a coming attraction.

Here's how to take the first step.

By Audrey Alflen

hinking back three years, I remember visiting a practice that had been buried in paper for many years. Charges and payments were tracked on a daybook sheet. Insurance claims were hand typed in duplicate. Trays and trays of ledger cards lined the receptionist's desk. Yes, the practice survived this way for many years, but things were getting out of hand. Charges were slipping through the cracks unnoticed. Payments were often posted incorrectly. Balance billing was not frequently done. Statements were sent as often as possible, usually every three months. This was a practice in desperate need of help. As I travel from office to office and from town to town, I see this story replayed again and again. The challenge is to catch the struggling, paper laden practice before it falls too far into the paper bog.

Computerization. Is it right for every office?

No. There are many variables from office to office. Production, patient volume, future practice plans and personnel are all issues to consider. As we all know, the practice of medicine is changing rapidly. Computers are much more affordable in today's market. Software features have expanded beyond tracking charges and payments and billing insurances to include appointments scheduling, medical reminders, management and statistical reports, HMO profitability tracking, collection tracking, medication tracking and medical record automation.

Software for the medical practice varies greatly from vendor to vendor. The practice should first assess its particular needs, weighing the pros and cons of an in-house system versus an on-line (service bureau) system, or even an off site billing service. A simple way to do this is to put a "wish list" down on paper. Think of any functions you or your staff may be doing which could be automated. In no time you will have the start of your list.

Choosing a computer can be difficult. Vendors are often represented by experienced, well trained sales people. It is easy to feel dazzled and overwhelmed by a smooth demonstration. A billing clerk struggling to maintain order in a paper system may want to jump at the first software offering a computer generated

claim form. Don't allow yourself to be swept off your feet. Prepare a script of questions for the sales representative. As you review software and hardware possibilities, you will become more familiar with system capabilities and the "lingo" of computer sales people. Expand your script and measure each system against the same set of criteria. Be certain that the system is going to give you what you want for your practice. Focus on the following four key criteria software, hardware, company expertise and stability, and training and support. These categories must be carefully evaluated to make an informed decision.

A computer purchase or installations can be **expensive.** A solo practice may spend from \$12,000 to \$25,000 to purchase a system. This expenditure must be balanced against the benefit to the practice. Improved claim processing resulting in clean claims will increase and speed reimbursement. The practice mentioned at the beginning of this article is now computerized. The office manager and staff that had been a part of the practice three years ago are amazed. The piles of paper are gone. The trays of ledger cards are gone. In their place? Clean counters and neatly organized computer reports filed for easy access. Oh, by the way, the physicians are happy! Charges and payments have increased considerably. Are the physicians seeing more patients? Not significantly. The difference? The cracks previously allowing charges to slip by unposted and payments or write-offs processed incorrectly have been sealed.

Patients' balance statements are printed and mailed in cycles every week. Cash flow has greatly improved. Once the staff became accustomed to the computer, they began submitting claims via electronic communication. The results? A happier, more productive staff, a cleaner, more efficient office and a more profitable practice. The cost of installation is usually minimal. Computers are smaller than ever. Often the processing unit can fit under a desk. The terminals and keyboards take no more room than a typewriter. Wiring can usually be run over ceiling tiles. A reputable vendor will help you through this process step by step.

Continued on following page

Continued from page 17

**Concerned about your staff?** Can they adapt? Do they have any understanding of computers? These worries can be quickly put to rest by having a good vendor train your support staff. If the staff is involved in the review process and

decision making for a computer, they are usually both quite excited and less apprehensive. A good software program will be logical and easy to understand. The staff deserves the chance to prove themselves on the computer. Some medical office employees may find it difficult to change from the way things have always been done. They may fall back or rely on old methods. This is a time to involve vendor training and support, and possibly a practice management consultant. With adequate training from the vendor and a little self confidence, most staff members will quickly adapt to the age of automation. It is unlikely that a computer will displace a key person. Rather, the computer will al-

low that person to work more efficiently and effectively. Follow up on unpaid claims and other miscellaneous tasks related to billing often stack up on the desks and in the files of billing personnel. Automation will provide the necessary reports and time to work on these all too often neglected problems.

Electronic billing is more than just a coming attraction. It is here now. Be sure any system you consider has the capability of communicating electronically with Blue Cross Blue Shield of Michigan. The EDI department of BCBSM will be happy to provide you with matrix of information on vendors able to communicate with them directly.

#### Before you take the plunge, consider the following suggestions:

- 1. Ask colleagues about their system, visit their office to see the system in action.
- 2. Ask your practice management consultant about reputable vendors.
- 3. Check the strength and viability of the vendor.
- 4. Contact Blue Cross Blue Shield of Michigan to assure that the system you are considering is compatible with the EDI department.
- 5. Check reference. Buying a computer is like hiring a new staff person. Make sure that it is a good fit.
- 6. Review service contracts. Beware of hidden costs.
- Make certain the vendor offers convenient training and excellent support. Check the support department size

- and hours of services. Also ask if support can be reached via a toll free number.
- 8. Involve your staff in discussions about computerization.
- 9. Review your "wish list" and determine if the system fits your requirements.

10. Be certain that the vendor will provide you with necessary updates as insurance requirements change.

Computerizing an office is a big step. But relax, you already have what it takes to start the process of inquiry. Now gather the data needed to make an informed decision and move forward.

Audrey Alflen is a practice management consultant with Professional Management of Grand Rapids, Inc. (The PM Group).

Choosing a computer can be difficult. Vendors are often represented by experienced, well trained sales people. It is easy to feel dazzled and overwhelmed by a smooth demonstration. A billing clerk struggling to maintain order in a paper system may want to jump at the first software offering a computer generated claim form. Don't allow yourself to be swept off your feet.

#### MSMS Committee on Technology in Medicine

MSMS recently established its Committee on Technology in Medicine. Following are the members of the Committee:

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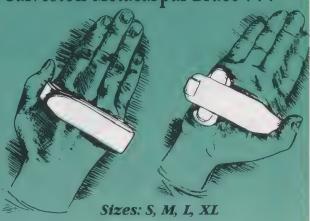
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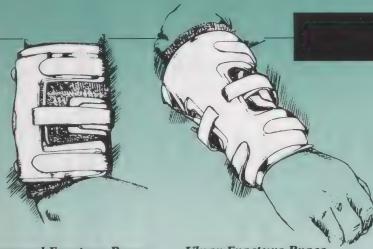
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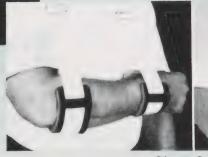
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## JOHN W. FINN, MD.

"It is a privilege to care for the dying",

By Helen Fordham

o everything there is a season, and a time to every purpose under heaven: a time to be born and a time to die." Even though we recognize the inevitable cycle referred to in this line from Ecclesiastes most of us are still not comfortable with the thought of death. Not so for John W. Finn, MD, medical director of Hospice of South Eastern Michigan, who daily helps patients prepare for death.

"It is a privilege to care for the dying," explains Doctor Finn, an internist who has been medical director for five years. "I am more comfortable at the bedside of a dying patient," he admits, "than fostering unrealistic expectations or false hopes."

In a society that shies away from death, this embracing of the dying process is rare. Death is an important part of life, says Doctor Finn, and it should not be feared or ignored. "We choose our own responses (to death)," he adds. "We can be crushed by it or ennobled by it."

Yet ignoring death or seeing it as a failure is a part of how the medical professional is socialized into viewing death, according to Doctor Finn. Indeed, most conventional medical efforts are focused on prolonging life at any cost, he says, and this can add to a dying patient's distress. In this technological age more people die from treatment and treatment-related illnesses, he explains, than the actual disease.

#### Soul searching led to Hospice choice

Doctor Finn's involvement with dying patients is not new. Throughout medical school he was drawn to terminally ill patients. During an oncology fellowship he spent an elective working with Hospice, which led to some serious soul searching about his professional focus. "That's when I determined I was more suited to Hospice than to practice as a traditional oncologist," he says.

During the hospice elective, Doctor Finn had the opportunity to examine the conventions of caring for the dying. He found that with the emphasis on medical technology disease had been separated from the patient. Physicians are trained to treat the disease, he adds, and in doing so have lost the perspective of the patient and family. It was the unaddressed issues associated with dying that concerned him. "Issues of pain control and family stress and coping; issues of futility

(Patients) want physicians
who will share their humanity with them.
They want someone who will listen
and show they care,
even in the face of death...
I've come to grips
with my own mortality
and the deaths in my life, and
I want to do something positive
with that. I want to do
something for the dying.

were relegated to the second and third order of importance," he explains.

Doctor Finn ascribes to a more holistic, more personcentered approach to patients. In his experiences this is what patients want. "(Patients) want physicians who will share their humanity with them," he says. "They want someone who will listen and show they care, even in the face of death." He acknowledges that this can be difficult for some physicians because the medical system is so dehumanizing.

Doctor Finn's attitude toward death is partially influenced by his own personal losses. "I've had plenty of experience with death," he explains. He lost his mother to a painful illness when he was only 17. Eleven years later his father also died. More recently his baby daughter, Rebbecca, died. "I've come to grips with my own mortality and the deaths in my life," he explains, "and I want to do something positive with that. I want to do something for the dying."

This acceptance of death better prepares Doctor Finn to help his terminal patients face their own deaths. He admits to sometimes feeling powerless to affect the progress of a terminal disease. He has, however, learned that he can provide immeasurable comfort by explaining the disease to the patient and family and by reassuring patients they will die a peaceful, dignified death.

"Most physicians feel at a total loss with a dying patient,"



explains Doctor Finn. "They don't realize that just their presence at the bedside is powerful."

With his unique view of death, it is not surprising Doctor Finn was drawn to Hospice. "Hospice is not a right to die organization," he explains. "It affirms life. We recognize death is a part of life. We don't do anything to hasten death or prolong life." He found Hospice's focus on alleviating suffering a unique way of combining the science of medicine with the art. "It is the experience of caregiving in the technological age," he says.

Doctor Finn has seen many patients die during his years with Hospice. Currently more than 450 patients are being cared for at home by Hospice teams. He admits sometimes he becomes battle fatigued by the constant loss but his faith helps keep him balanced. "I couldn't do this work without my Christian framework," he says. "There is so much despair."

He did despair several years ago when, after the death of his daughter, he seriously questioned his role as a physician. "I was not sure that what I was doing was legitimately medical," he says. He went to England to observe their Hospice system and while there renewed his commitment to helping terminal patients die peaceful deaths. "I realized that Hospice care is more true to the tradition of medicine than what we currently do in hospitals."

Regardless of the setting - home or hospital - helping people die can be difficult. Doctor Finn says

he has difficulty with sedating patients with troublesome symptoms and providing medication that may hasten death. He adds, though, that he will do both if it is in the patient's best interests. In his experience he has found that he has the most difficulty with families and the way their feelings about the patient affect the care-taking decisions. "Many want to hold onto unrealistic expectations," he explains, "and out of guilt may demand futile care."

In spite of the difficulties, Hospice work is extremely satisfying for Doctor Finn. "Making an impact on the quality of life or bringing peace to a distraught family is very gratifying," he says. The strength and integrity of the human spirit is constantly inspiring and the gratitude of the families is hugely rewarding. "The patients end by giving you more than you can ever give them," he adds.

#### Many lessons learned

Doctor Finn has learned a great deal from his patients. "I've learned there are few deathbed conversions," he says, "and people die as they have lived." He has seen people grow spiritually, he has seen patients refuse pain medication because of their religious beliefs and he has seen others hold out hope until the very end. "Some people don't make sense of life until they are dying," he says. Yet,

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he has seen miracles on other levels: families reconciled and old grievances resolved.

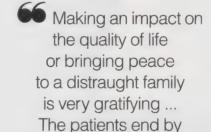
One patient who taught Doctor Finn about difficult choices was David Rivlin, a young respirator-dependent quadriplegic, who petitioned the Michigan courts to affirm his right to withdraw life-sustaining treatment. "David was troubling because he wasn't terminally ill," Doctor Finn explains.

"David taught me something pertinent to Hospice patients," he adds. "Most patients are not choosing death. They are choosing to live a certain way. David was choosing to live free of the machine knowing full well he couldn't live without the machine.

"When people come to Hospice they are choosing comfort over survival and choosing a peaceful death over intrusive techniques and technologies."

People that come to Hospice don't want life prolonged, according to Doctor Finn, but they are not suicidal. Indeed they are rational. "People come because they want comfort care at home," he says.

Many can see a fine line between helping terminal patients die comfortably and Doctor Kevorkian's assisted suicide. Doctor Finn, while accepting the inevitability of death, does not believe in assisted suicide. To ask others for



giving you more than you can ever give them.

assistance in suicide is selfish and cowardly, he says, in the sense that it hurts survivors. "It is a lot to ask of another human being."

Doctor Finn points to a painting on his wall, entitled "The Doctor" by Sir Luke Field. It depicts a dying child and a physician sitting quietly by her bedside. The physician's concern and compassion is evident in every stroke. "This captures what I went into medicine for," says Doctor Finn, "to take care of the patient."



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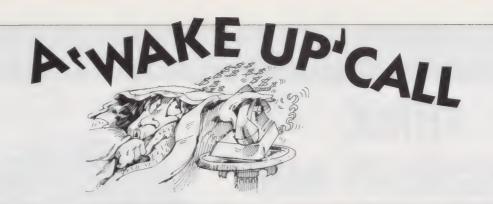
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#### IT'S TIME TO FOCUS ON FINANCES

By Thomas R. Berglund, MD

laintiff attorneys and allegations of medical malpractice dominated the thoughts of physicians in the mid 1970s. Like a bad dream, that dominance triggered liability insurance premium nightmares.

Now, we're getting a "wake-up" call to a new era: a period when auditors and actuaries step up efforts to mark and clear pathways for financial stability and solvency.

Today, the focus is on the financial capacity of your insurance company to protect your professional and financial interests.

The National Association of Insurance Commissioners (NAIC) has been developing capital and surplus standards

for various insurance product lines. This effort underscores the nationwide attention to solvency.

Financial turbulence in the savings and loan industry set the stage for the new focus. Government and legislative initiatives sharpened the image.

Policyholder concerns outlined and colored the view. Solvency issues give us a rude awakening.

It's been reported that in the past year, Standard & Poor's Corp. (a financial rating service) downgraded more than 20 major insurance companies. Moody's Investors Service. Inc. lowered ratings on six major life insurers.

Continued on page 29

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Thomas R. Berglund, M.D.

President & Chairman of the Board
Michigan Physicians

Michigan Physicians
Mutual Liability Company

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The insurance availability crisis of the mid 1970s and the elevating premium crisis of the mid 1980s left us with a bitter after-taste.

Doctor Berglund is president and chairman of the board, Michigan Physicians Mutual Liability Company.

#### Key questions to ask

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- 1. If the company went out of business today, would it have enough assets to handle its obligations?
- 2. Is the company charging adequate premiums, given the liability climate and trends?
- 3. Is there enough money set aside to cover pending claims?
- 4. Has the company been successful in building surplus, or is the company struggling or failing financially?
- 5. Does the company have enough experience in this volatile line of business?
- 6. Is there a commitment to policyholders and the medical profession?

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July 1993



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(formerly CBC) or 1-800-444-010 (formerly Advance Medical).



## National Coalition of Physicians Against Family Violence

More than 180 Michigan physicians, alliance members, and professionals are now involved

uring the past two years, as part of its campaign against family violence, the American Medical Association (AMA) has been recruiting members into a National Coalition of Physicians Against Family Violence, Membership has been free of charge and open to interested physicians, Alliance members, and professionals working in the fields of public health and advocacy. There are now approximately 4,000 members in the coalition, more than 180 of whom are Michigan physicians. All have received a membership packet that includes the set of four AMA Diagnostic and Treatment Guidelines on Child Abuse and Neglect, Child Sexual Abuse, Elder Abuse and Neglect and Domestic Violence.

MSMS salutes the approximately 181 Michigan physicians, alliance members and working professionals who have joined the Coalition. Following are the names of those individuals who are members of the Coalition as of March 22, 1993:

Tama Abel, MD, Ann Arbor Mary Anne Adams, East Lansing Carlo Miguel Adan, Midland Sohail I. Ahmad, Port Huron Elizabeth Aldridge, MD, Ann Arbor Robert D. Allaben, MD, Detroit Jonathan Alley, DO, Lansing Mary S. Amoe, Ann Arbor Dianne Ansari, MD, Lansing Alida Asencio, MD, Cheboygan Catherine Baase, MD, Saginaw Gail Bagale, Dearborn Lynda Baker, Westland Joseph M. Beals, MD, Detroit Donnie Sue Beasley, DO, Lansing John Behm, DO, Lansing Elissa Benedek, MD, Ann Arbor Steven H. Berger, MD, Grand Rapids Ernest M. Berkas, MD, Dearborn John Boyer, MD, Detroit Barbara Bradley, MD, Grand Rapids James W. Brasseur, Greenville Sander J. Breiner, MD, Farmington Hills Russell L. Bush, MD, Lapeer Jacquelyn Campbell, PhD, RN, Detroit Virginia Caradonna, MD, Birmingham Mary Alice Carbeck, Ann Arbor Jean Chabut, Okemos Maurice H. Chapin, MD, Millington Bonny Chen, Ann Arbor John M. Cilluffo, MD, Petoskey Cindy Cleland, Escanaba Jean C. Cline, MD, Traverse City John C. Colwill, MD, Grand Rapids Michelle M. Condon, MD, East Grand Kathleen M. Cowling, DO, Bath Nelu Cristof, MD, Livonia Joseph C. Dagostino, DO, Lansing Niketa Dani, East Lansing Robert J. Darios, MD, Lansing Mary Davis, MD, Novi Nancy J. Diehl, Detroit Robert W. Dixon, Jr., MD, Grand Haven Cheryl Farmer, MD, Ann Arbor Robert Fawcett, MD, Petoskev

Kenneth Fink, DO, Farmington Karen Flory, East Lansing Jessica Friday, Onaway Sarah Funkhouser, Lansing Michael Fusillo, MD, Allegan William P. Gifford, MD, Lansing Gina Gora, Okemos Aloma Jean Grein, Reed City Bernard Gros, Ann Arbor Elly Hann, DO, Troy Mary Ann Hansen, Traverse City Kirk R. Hasenmueller, MD, Lansing Gail Haynes, Grand Rapids Tom Haynes, Grand Rapids Catherine A. Henry, MD, Detroit Rose P. Hernandez, DO. Saginaw Chuck Heyka, MD, Petoskey Rock Heymen, JD, Detroit David K. Hickok, MD, Kalamazoo Jane Higgins, Kalamazoo Sherman W. Horn, II, Charlotte Genesis House, II, Detroit Robert Den Houten, Lansing James J. Hoyne, DO, Lansing Timothy J. Izzo, DO, Lansing Joe S. Jacob, PhD, MD, Ann Arbor Beverly Jensen, East Grand Rapids Anne M. Joannides, St. Clair Shores James W. Johnson, MD, Auburn Hills Patricia Johnson, Big Rapids Valerie K. Johnson, DO, Lansing Pete Jones, MD, Lansing B.D. Juriansz, MD, Essexville T. Karabey, MD, Farmington Hills Kimberly E. Keller, MD, Ypsilanti John C. Kennedy, MD, Canton Benedict Kim, East Lansing Juen Kim, Ann Arbor D'Anne Klein-Smith, MD, West Bloomfield Cassandra M. Klyman, MD, Bloomfield Hills M.A. Kosier, MD, Allen Park Cathy A. Kukula, PA, Hamtramck Nita M. Kulkarni, Ann Arbor Luana J. Kyselka, MD, Troy Kim C. Landis, MD, Lansing Cynthia S. Lane, Detroit Sara Lawrence-Zeko, Lansing Judy Lee, Pontiac Sherry Lessens, Shelby David J. Lieberman, MD, Monroe Virginia Mehregan, Monroe Mable Meites, Okemos Barbara L. Merrill, DO, Lansing Virginia Y. Mesa, MD, Flint Alvin B. Michaels, MD, Bingham Farms Joan Michener, MD, Lansing Barbara K. Miller, MD, Gladwin Alan Mindlin, MD, Bloomfield Hills Joyce Moot, Ann Arbor Elizabeth Mosher, Charlevoix C. Michael Moyes, East Lansing Terry L. Nagel, DO, Lansing Torry S. Nash, MD, Grand Rapids

Continued on following page

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For more information on the National Coalition of Physicians Against Family Violence, contact Judy Marr at MSMS 517/337-1351.



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Director, National Immunization Program Centers for Disease Control and Prevention

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#### For more information, contact:

Nancy Fasano

Immunization Section
Michigan Department of Public Health
P. O. Box 30035, Lansing, MI 48909

Phone: (517) 335-9423

Science and Practice of Childhood Immunization in Michigan

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Registration fee (includes lunch): \$20, payable by check to State of Michigan at address above.



## MSMS LEGAL BRIEFS

Editor's note: The following information is provided by MSMS legal counsel, Kerr, Russell & Weber, Detroit. If you have a legal question you would like answered in this column, jot it down and send it to Betty McNerney, Editor of Publications, at MSMS.

## The Michigan Limited Liability Company . A new structure for medical practice

By James R. Cambridge

ichigan physicians and other professionals now have a new entity to use the limited liability company ("LLC"). On June 1, 1993, the Michigan Limited Liability Company Act became effective, authorizing the formation and operation of LLCs in Michigan. An LLC is a cross between a partnership and a corporation and combines the most favorable attributes of both. The LLC has been designed to provide owners and managers with the flexibility and tax advantages of a partnership and the protection against personal liability of a corporation. Michigan physicians who have practiced in the form of partnerships or professional service corporations in the past will be able to use an LLC for their practices. The LLC may also be a way for physicians to affiliate as Physician Organizations. The LLC is expected to provide new opportunities and alternatives for practicing and doing business in Michigan.

The LLC is an unincorporated business entity under which neither its owners (known as members) nor those running the business (known as managers) will be personally liable for the obligations of the LLC. If properly structured, the LLC will also be treated as a pass-through entity for federal income tax purposes and will not be subject to federal income tax at the entity level. Rather, all items of income. gain, loss, deduction and credit will pass-through directly to the owners of the business. Because of the higher corporate tax rate (at least for now), the double taxation of corporate profits at both the corporate and shareholder level and the other tax consequences of incorporation, a pass-through entity such as an LLC is very attractive from a tax standpoint. The addition of the corporate attribute of limited liability makes the LLC even more attractive.

#### Corporate characteristics

The Michigan LLC was designed around four corporate characteristics that the Internal Revenue Service has traditionally looked for in determining whether an unincorporated business entity will be treated as a corporation for tax purposes. Generally, an unincorporated business entity cannot have more than two of the corporate characteristics of limited liability, centralized management, continuity of life and free transferability of interests if it is to avoid being considered a corporation for tax purposes. An LLC automatically has limited liability. The Michigan LLC has been designed to give members the flexibility of choosing one more corporate characteristic of the three remaining. With no more than two corporate characteristics in hand (one

automatically being limited liability), the Michigan LLC should qualify as a pass-through entity for federal income tax purposes and owners should be able to avoid federal income tax at the entity level. A Revenue Ruling by the IRS will be sought.

#### Who can organize

Two or more persons may organize and become members of an LLC. However, individual members and managers of a professional LLC must be licensed to provide the professional services of the LLC and only duly licensed individuals can render professional services. If a professional LLC renders a service that is included in the Public Health Code (such as the practice of medicine), then all members and managers of the professional LLC must be licensed or legally authorized to render the same professional service.

Although some liability can be avoided by using a professional LLC, not all liability can. Each professional will still be liable for that professional's own negligence, wrongful acts or misconduct or that of any person under the professional's direct supervision. A professional LLC will also remain liable itself up to the full value of its property for the negligence, wrongful acts or misconduct of any of its members, managers, employees, or agents while they are acting on behalf of the professional LLC in the rendering of professional services. Similar provisions are contained in the Michigan Professional Service Corporation Act.

#### How to form an LLC

Organizing an LLC is very similar to setting up a corporation. To form an

Continued on following page

#### **LEGAL BRIEFS**

Continued from page 35

LLC, Articles of Organization must be filed with the Michigan Department of Commerce. The Articles of Organization of a professional LLC must state that the LLC is formed to render specified professional services. The professional LLC will not be able to engage in any other business. The name of a professional LLC must contain the words "Professional Limited Liability Company" or the abbreviation "P.L.L.C." or "P.L.C."

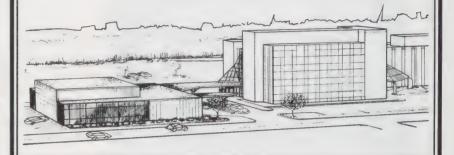
Currently, 25 states have adopted some version of LLC legislation and about 20 others are considering doing so. Michigan is the first industrial state in the country to have this new form of business entity and Michigan's treatment of professional LLCs is somewhat unique.

#### Many benefits

Michigan physicians may be interested in using an LLC for their practices instead of using partnerships or professional service corporations. An LLC will provide physicians with the flexibility and tax advantages of a partnership and the protection against personal liability of a professional service corporation. The LLC may provide a means of consolidating separate medical practices into groups such as Physician Organizations while preserving existing employment relationships. The LLC may also be a useful device for physicians to conduct joint ventures and real estate investments. As more and more states adopt LLC legislation and business planners and professionals grow more accustomed to this form of practice, the LLC may very well become the new entity of choice in Michigan and elsewhere.

James R. Cambridge is a partner in the law firm of Kerr, Russell & Weber. He served as chairperson of the Legislative Drafting Committee of business and tax lawyers that wrote the Michigan Limited Liability Company Act.

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## **Board of Medicine Actions**

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Commerce, Office of Health Services.

Name: Jaime Ayala, MD, 37677 Professional Center Dr., Suite 125C, Livonia, MI 48154

**Action, Date Taken:** License Suspended- 10 days, Fined \$500.00, 04-30-93

Reason: Conv/Insurance Fraud

Name: James Howard Dallman, MD, 800 Lyncott Street, North Muskegon, MI 49445

**Action, Date Taken:** Reprimand, Fine \$500.00, 04-21-93

**Reason:** Practice Below Acceptable Standards

Name: Joann M. Gates, MD, 1695 Woodward Avenue, Suite 103, Bloomfield Hills, MI 48302

Action, Date Taken: Summary Suspension, 03-17-93

Reason: Drug Related

Name: Daniel James Link, MD, 124 Charles Road, Rochester, MI 48307 Action, Date Taken: Granted Educational Limited License, Probation, 2

tional Limited License, Probation- 2 years, 05-10-93

Reason: Conv/Criminal Sexual Conduct

Name: Michael A. Marshall, MD, 23300 Providence Dr., Apt. 516, Southfield, MI 48075

**Action, Date Taken:** Reinstatement Denied, 03-24-93

Name: John D. McAllister, MD, P.O. Box 15538, Durham, NC 27704

**Action, Date Taken:** License Revoked, 06-09-93

Reason: Substance Abuse

Name: Nathan E. Pearson, Jr., MD, 23888 Evergreen Rd. #230-C, Southfield, MI 48075

**Action, Date Taken:** License Reinstated, 03-04-93

Name: Cesario Solarte, Jr., MD, 5113 Longview Drive, Troy, MI 48098

**Action, Date Taken:** License Suspended- 6 months, Fine \$500.00, Voluntary Surrender of Controlled Substance License

Reason: Drug Related

Name: Thomas Michael Truemann, MD, 29829 Telegraph Rd., #100, Southfield, MI 48034

**Action, Date Taken:** Summary Suspension, 03-17-93

**Reason:** Mental/Physical Inability to Practice-Drug/Alcohol Related

Name: Joseph C. Ward, MD, 3855 E. Leonesio Way, #D-2, Reno, NV 89512 Action, Date Taken: License Limited, Probation- 3 years, 05-21-93

**Reason:** Mental/Physical Inability to Practice-Drug/Alcohol Related

Name: Henry J. Winkler, MD, 9139 Cadieux, Detroit, MI 48224

Action, Date Taken: License Suspended- 2 years, 06-09-93

Reason: Drug Related





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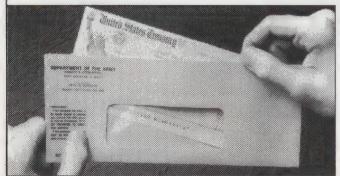


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## **OBITUARIES**

#### Donald Chandler, MD

**Grand Rapids** 

Donald Chandler, MD, a retired surgeon died March 3, 1992. He was 96. A 1917 graduate of Haverford College and a 1923 graduate of Johns Hopkins University Medical School, Doctor Chandler was a member of the Kent County Medical Society and MSMS.

#### Ralph H. Gilbert, MD

Grand Rapids

Ralph H. Gilbert, MD, a retired ophthalmologist, died March 1, 1992. He was 81. A 1934 graduate of the University of Wisconsin College of Medicine, Doctor Gilbert was affiliated with Butterworth, Blodgett and St. Mary's Hospitals. He was a member of several specialty societies, Kent County Medical Society and MSMS.

#### Philip J. Howard, MD

North Claredon, VT

Philip J. Howard, MD, a retired pediatrician, died February 3, 1992. He was 92. A graduate of Connecticut Wesleyan and Harvard University Medical School, Doctor Howard was a past president of Wayne County - Detroit Pediatric Society and past state chairman of American Academy Pediatrics - Michigan Chapter. He was a member of several specialty societies and MSMS.

#### William K. Howard, MD

Detroit

William K. Howard, MD, a pediatrician, died March 23, 1993. He was 68. A graduate of Vanderbilt University, Doctor Howard was affiliated with Metropolitan, Childrens and Hutzel Hospitals.

He was a clinical assistant professor at Wayne State University, and was a member of MSMS.

#### **Lawrence Lackey, MD**

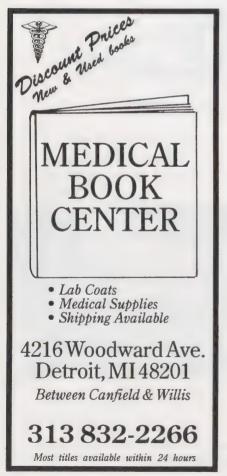
River Rouge

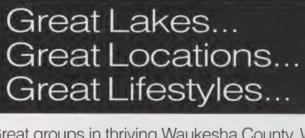
Lawrence Lackey, MD, an internist, died February 13, 1993. He was 74. A graduate of Langston University and the University of Kansas, Doctor Lackey was affiliated with Outer Drive Hospital, Lincoln Park. He was a member of Wayne County Medical Society and MSMS.

#### Thomas A. Petty, MD

Grosse Pointe

Thomas A. Petty, MD, a retired psychiatrist, died February 27, 1993. He was 74. A graduate of Indiana University School of Medicine, Doctor Petty was past president, treasurer and chairman, ethics committee, Michigan Psychiatric Society. He was a member of several specialty societies and MSMS.





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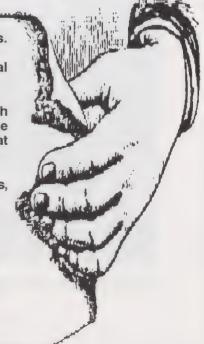
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## **MEETINGS**

#### **MSMS Meetings**

#### July

**14-18,** MSMS Midsummer Board Meeting, Shanty Creek, Bellaire, Ml. William Madigan, MSMS Executive Director, (517) 336-5734.

#### September

**29,** MSMS Effective Compassion for the Incurably III: Alternatives to Assisted Suicide, Holiday Inn, Flint, MI. Contact: Judy Marr, MSMS Communications, (517) 336-5744.

#### October

**27,** MSMS Effective Compassion for the Incurably III: Alternatives to Assisted Suicide, Westin Hotel, Detroit, MI. Contact: Judy Marr, MSMS Communications, (517) 336-5744.

#### November

**9-11,** MSMS Annual Scientific Meeting, Westin Hotel, Detroit, Ml. Contact: Sarah Cressman, MSMS Assistant for Physician Education, (517) 336-5727.

**24,** MSMS Effective Compassion for the Incurably III: Alternatives to Assisted Suicide, Fetzer Center, Kalamazoo, MI. Contact: Judy Marr, MSMS Communications, (517) 336-5744.

#### Michigan Specialty Society Meetings

#### August

**14-20,** The Twelfth Annual Scientific Meeting and Exhibition of the Society of Magnetic Resonance in Medicine. Contact: Society of Magnetic Resonance in Medicine, Inc., (510) 841-1899.

#### National Specialty Society Meetings

#### October

**13-17,** American Society of Internal Medicine Leadership Development Conference, Portland, OR. Contact: Melinda Klein, (202) 835-2746, ext. 266.

**29-31,** American Society of Bariatric Physicians, Westin Hotel, Chicago, III. Contact: (303) 779-4833.

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## **CATEGORY I COURSES**

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

#### July

11-13, 7th Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management. Location: Grand Traverse Resort Village, Grand Traverse Resort, Michigan. Sponsor: University of Michigan Medical School, Department of Radiology. Contact: Marie McKnight, Towsley Center for Continuing Medical Education, Depart-

ment of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157. **Approved for:** 15 hours Category I Credit.

22-25, Ninteenth Annual Mackinac Island Course: Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island, Michigan. Sponsor: University of Michigan Medical School, Division of Infectious Diseases, Department of Internal Medicine. Contact: Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Michigan State Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, I 48106-1157, (313) 763-1400. Approved for: 13 hours Category I Credit.

**22-24,** Advances in Office Psychiatry II: Mood and Anxiety Disorders. Location: Grand Traverse Resort, Grand Traverse Resort Village, Michigan.

**Sponsor:** University of Michigan Medical School and the Michigan Psychiatric Society. **Contact:** Registrar, Office of Continuing Medical Education, University of Michigan Medical School, PO Box 1157, Ann Arbor, MI 48106-1157, (313) 936-9800. **Approved for:** 12 hours Category I Credit.

**29-30,** 73rd Annual Coller Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City, Michigan. **Sponsor:** Munson Medical Center and Medical Staff. **Contact:** Elaine Gaines, Medical Education, Munson Medical Center, 1105 Sixth St., Traverse City, MI 49684-2386, (616) 935-6546.

#### August

**8-11,** Internal Medicine Update. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Marie

Continued on following page

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47

#### CATEGORY I COURSES

Continued from page 47

McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 12 hours Category I Credit.

23-28, Pediatric Board Review. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Michigan Association of Pediatric Program Directors, Michigan Chapter, American Academy of Pediatrics. Contact: Marie McKnight, Registrar, Towsley Center for Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 936-9800. Approved for: 60 hours Category I Credit.

#### September

**9-10,** Critical Clinical Issues in the Care of the Elderly: Oral Health, Dysphagia, Aspiration and Pneumo-

nia. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan and Cleveland Regional Medical Education Center, Department of Veteran Affairs. Contact: Marie McKight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. Approved for: 7 hours Category I Credit.

**15,** Diagnosis and Management of Myocardial Infarction. Location: Grand Traverse Resort, Traverse City, Michigan. Sponsor: Michigan State Medical Society and Michigan Physicians Mutual Liability Company. Contact: Julie Smith, MSMS Chief, Risk Management, (5.17) 337-1351. Approved for: 6.5 hours Category I Credit.

**20-21,** Update on Pulmonary and Critical Care Medicine. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Department of Internal Medicine. Contact: Marie McKnight,

Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 15 hours Category I Credit.

**22, 23,** Diagnosis and Management of Myocardial Infarction. Location: September 22, Novi Hilton, Novi, Michigan. September 23, WMU Regional Center, Grand Rapids, Michigan. **Sponsor:** Michigan State Medical Society and Michigan Physicians Mutual Liability Company. **Contact:** Julie Smith, MSMS Chief, Risk Management, (517) 337-1351. **Approved for:** 6.5 hours Category I Credit.

29, Effective Compassion for the Incurably III: Alternatives to Assisted Suicide. Location: Holiday Inn, Flint, Michigan. Sponsor: Michigan State Medical Society. Contact: Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48826-0950, (517) 336-5784. Approved for: 6 hours Category I Credit.

Continued on page 50



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## CATEGORY I

Continued from page 47

#### October

**5, 6, 7,** Providing Outstanding Patient Service. Location: October 5, Treasure Island, Saginaw, Michigan. October 6, Novi Hilton, Novi, Michigan. October 7, MSMS Headquarters, East Lansing, Michigan. **Sponsor:** Michigan State Medical Society. **Contact:** Office of Physician Education, (517) 336-5784. **Approved for:** 6.5 hours Category I Credit.

27, Effective Compassion for the Incurably III: Alternatives to Assisted Suicide. Location: Westin Hotel, Detroit, Michigan. Sponsor: Michigan State Medical Society. Contact: Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48826-0950, (517) 336-5784. Approved for: 6 hours Category I Credit.

#### November

**3, 4,** Diagnosis and Management of Colon & Prostate Cancer. Location: November 3, WMU Regional Center, Grand Rapids, Michigan. November 4, Novi Hilton, Novi, Michigan. **Sponsor:** Michigan State Medical Society and Michigan Physicians Mutual Liability Company. **Contact:** Julie Smith, MSMS Chief, Risk Management, (517) 337-1351. **Approved for:** 6.5 hours Category I Credit.

23-28, Pediatric Board Review. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Michigan Association of Pediatric Program Directors, Michigan Chapter, American Academy of Pediatrics. Contact: Marie McKnight, Registrar, Towsley Center for Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 936-9800. Approved for: 60 hours Category I Credit.

**24,** Effective Compassion for the Incurably III: Alternatives to Assisted Suicide. Location: Fetzer Center, Kalamazoo, Michigan. Sponsor: Michigan State Medical Society. Contact: Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48826-0950, (517) 336-5784. Approved for: 6 hours Category I Credit.



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#### References:

- A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
- Goodman, Gilman The Pharmacological basis of Therapeutics 6th ed., p. 176-188.
   McMillan December Rev. 1/85.
- 3. Weekly Urological Clinical letter, 27:2, July 4, 1983
- **4.** A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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## PRESIDENT'S PAGE

### **Target Tomorrow**

By Gilbert B. Bluhm, MD

embership retention and recruitment is one of three key themes of my presidency. As I have already discussed my other two themes – health care reform and adolescent preventative health – in previous president's pages, I will devote this month's page to membership retention and recruitment.

Without a doubt, physician membership is vital to MSMS. It is crucial that

MSMS satisfies the needs of its members. It is equally important that MSMS members take an active role in helping recruit new members. New members provide diversity, increased clout, added energy to help accomplish goals, and financial support to help offset MSMS operational expenses. There are too many nonmember physicians who don't know, or take for granted, the fact that MSMS and the AMA function as advocator, initiator and monitor for our patients and profession.

Organized medicine in this state and nationally must anticipate, prepare and modulate successfully the health issues for the betterment of our patients and us. While we are 11,900 strong, we still lack input from about 25-30 percent of the licensed physicians in Michigan who are non-members of MSMS; and thus, the AMA suffers too! The most successful recruitment in the last two

years has been with our IMG colleagues. Last year alone, almost twice as many new IMG members were recruited than non-IMGs.

A number of membership projects have been recom-



There are too many non-member physicians who don't know, or take for granted. the fact that MSMS and the AMA function as advocator, initiator and monitor for our patients and profession... The best recruiters are vou and I. One-on-one interaction is the best way to recruit our often indifferent, non-member colleagues. The opportunity beckons now!

mended and approved by the AMA for the states to implement on a "pilot trial" basis. Six states have successfully used the "unified" approach where a physician is required to become a member of the county-state society and the AMA. Pennsylvania is the most recent (1989) state to successfully utilize this approach. Two other states attempted the unified approach but were unsuccessful. Presently, special efforts are underway across Michigan to

recruit medical students and residents, Last year, Washtenaw County made significant progress. In 1992, MSMS and the Wayne County Medical Society agreed to work with the AMA on a membership pilot for a large group practice. The Henry Ford Medical Group agreed to the program. The increased percentages of female physicians in America (18 percent) and female medical school entrants (35-40 percent) have resulted in many adaptions and changes in state and AMA bylaws. A major effort has been to expand representative and leadership opportunities in the state and AMA for female physicians.

Those and other initiatives support our concern to renew our recruitment efforts on behalf of MSMS and the AMA. The best recruiters are you and I. One-on-one interaction is the best way to recruit our often indifferent, non-member colleagues. The opportunity beckons now! The necessity

and time are right. I ask you to make this year one of our best for recruitment. You will learn more details in the next several weeks about the MSMS membership program called "Target Tomorrow."

Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. Clin Cardiol. 1991;14:146-151.

#### PRAVACHOL® (Pravastatin Sodium Tablets) CONTRAINDICATIONS

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atheroscierosis is a chronic process and discontinuation of lipid-lowening drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitiors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they are cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient appressed of the potential hazards to the letus. patient apprised of the potential hazard to the fetus

patient apprised of the potential hazard to the letus.

WARNINGS
Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these solutions with choicestains and oil on displace no evitation to displace in our evitation of the properties of the properties where the properties were believed to be related to pravastatin and who were closer

rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin.

Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinua-

then therapy should be discontinued. Persistence or significant armitotransierase elevations indowing discontinued tion of therapy may warrant consideration of liver biopsy. Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported no pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (~0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tendemess or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tendemess or weakness, particularly if accompanied by malaise or fever. Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarly withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyofysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrohyte disorders; or uncontrolled epilepsy.

The risk of myopathy during treatment with loxastatin is increased if therapy with either cyclosporine, gemifitoral, enythornyoin, or nican is administered concurrently. There is no experience with the use of pravastatin together with nican. One trial of limited size involving combined therapy with pravastalin and gemifibrozil showed a trend loward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving giance to, genfibrozil, erpravastatin montherapy. Myopathy was not people and pravastatin treatment continued. The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatia and fibrates should generally be avoided.

PREC Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been re-

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin. Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients tack functional LDL receptors. Renal Insufficiency, A single 20 mg ora dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 5x-hydroxy isomeric metabolite (SQ 31,905), 6x-mall increase was seen in mean AUC values and alf-life (IV2) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945), Gent his small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin: See WARN-

: Skeletal Muscle Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cyto-

any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestynamine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the
mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days,
bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfanin. Concomitant dosing did increase the AUC and Cmax of warfarin hout
did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after
6 days of concomitant therapy). However, bleeding and extreme protongation of prothrombin time has been
reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is militated or the dosage of pravastatin is changed.

Cimetifine: The AUC\_12/m for pravastatin when given with cimetifine was not significantly different from the
AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin
when given with cimetifine compared to when administered with antacid.

AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolities SQ 31,906 and SQ 31,946 was not altered. Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil; there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant excrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with aspirin, antacids [1 hour prior to PRAWACHOL (pravastatin sodium)], cimetidine, nicotine acid, or probucol, no statistically significant differences in bioavailability were seen when PRAWACHOL was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers,

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with prawastatin in males and post-menopausal females were inconsistent with regard to possibile effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone responses to human chorionic gonadortopin was significantly reduced [p<0.00.4) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadortopin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononoclear cell Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower

infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg/dose.

Carcinogenesis, Mutagenesis, Impairment of Fartility: in a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose (p-6.01). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatian to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls (p<0.05). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times

either a dominant tental test in mice of a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily. These doses resulted in 20x (rabit) or 240x (rat) the human exposure based on surface area (mg/meter²). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAWACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL, should not nurse (see CONTRAINDATIONS)

CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: General.) ADVERSE REACTIONS

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal compliants. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% pravastatin-treated patients in the placebo-controlled trials are identified in the table below, also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

|                     | All Eve                  | nts %                | Events Attributed to Study Drug % |                      |  |
|---------------------|--------------------------|----------------------|-----------------------------------|----------------------|--|
| Body System/Event   | Pravastatin<br>(N = 900) | Placebo<br>(N = 411) | Pravastatin<br>(N = 900)          | Placebo<br>(N = 411) |  |
| Cardiovascular      |                          |                      |                                   |                      |  |
| Cardiac Chest Pain  | 4.0                      | 3.4                  | 0.1                               | 0.0                  |  |
| Dermatologic        |                          |                      |                                   |                      |  |
| Rash                | 4.0*                     | 1.1                  | 1.3                               | 0.9                  |  |
| Gastrointestinal    |                          |                      |                                   |                      |  |
| Nausea/Vomiting     | 7.3                      | 7.1                  | 2.9                               | 3.4                  |  |
| Diarrhea            | 6.2                      | 5.6                  | 2.0                               | 1.9                  |  |
| Abdominal Pain      | 5.4                      | 6.9                  | 2.0                               | 3.9                  |  |
| Constipation        | 4.0                      | 7.1                  | 2.4                               | 5.1                  |  |
| Flatulence          | 3.3                      | 3.6                  | 2.7                               | 3.4                  |  |
| Heartburn           | 2.9                      | 1.9                  | 2.0                               | 0.7                  |  |
| General             |                          |                      |                                   |                      |  |
| Fatigue             | 3.8                      | 3.4                  | 1.9                               | 1.0                  |  |
| Chest Pain          | 3.7                      | 1.9                  | 0.3                               | 0.2                  |  |
| Influenza           | 2.4°                     | 0.7                  | 0.0                               | 0.0                  |  |
| Musculoskeletal     |                          |                      |                                   |                      |  |
| Localized Pain      | 10.0                     | 9.0                  | 1.4                               | 1.5                  |  |
| Myalgia             | 2.7                      | 1.0                  | 0.6                               | 0.0                  |  |
| Nervous System      |                          |                      |                                   |                      |  |
| Headache            | 6.2                      | 3.9                  | 1.7*                              | 0.2                  |  |
| Dizziness           | 3.3                      | 3.2                  | 1.0                               | 0.5                  |  |
| Renal/Genitourinary | 0.0                      | 012                  | ,,,,                              | 010                  |  |
| Urinary Abnormality | 2.4                      | 2.9                  | 0.7                               | 1.2                  |  |
| Respiratory         | B. 1                     | 210                  | 011                               | 716                  |  |
| Common Cold         | 7.0                      | 6.3                  | 0.0                               | 0.0                  |  |
| Rhinitis            | 4.0                      | 4.1                  | 0.1                               | 0.0                  |  |
| Cough               | 2.6                      | 1.7                  | 0.1                               | 0.0                  |  |

"Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, verigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensithyty Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymygian bearing the present the procedure of the control of the contr one or more of the following features: anaphylaxis, angloedema, lupus erythematous-like syndrome, polymyaigh aneumatica, vasculitis, purpura, thrombocytopenia, leuhocopenia, hemohytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosenstivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome. Gastrointestrial: pancretistis, hepatitis, including chronic active hepatitis, choelstatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting. Reproductive: gynecomastia, oss of libido, erectile dysfunction. Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Ahnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed fees in MPAININGS.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed [see WARNINGS]. Transient, asymptomatic ecsinophilia has been reported. Ecsinophili counts usually returned to normal despite continued therapy, Aremia, thromborytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors. Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, produced and gemifibrozil. Preliminary data suggest that the addition of either probuciol or gemifibrozil is not associated with greater reduction in LDL-cholesterior than that achieved with lovastatin or pravastatin is not associated with greater reduction in LDL-cholesterior than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomydysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with mmunosuppressive drugs, gemifbrozil, erythromycin, or iglicil-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: Sketetal Muscle and PRECAUTIONS.) Troug Interactions.) Skeletal Muscle and PRECAUTIONS: Drug Interactions.)

CVERDOSAGE
There have been no reports of overdoses with pravastatin.
Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

## Effective lipid management doesn't have to be tough

- Improves key lipids significant reduction in LDL-C'
- Excellent safety profile
- Easy for patients once-daily dosing, well tolerated
- Usual dose: 20 mg once daily at bedtime, with or without food

# PISAVACIHOLI pravastatin socium 20 mg tablets

PRAVACHOL is indicated as an adjunct to diet for the reduction of elevated total and LDL-cholesterol levels in patients with primary hypercholesterolemia (Types IIa and IIb) when the response to diet alone has not been adequate

Active liver disease or unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of prayastatin sodium.

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.



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MEDICINE



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Award-Winning Journal of the Michigan State Medical Society





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Gilbert B. Bluhm, MD MSMS President 1993-94



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## **MICHIGAN MEDICINE**

AUGUST 1993 VOLUME 92, NO. 8

Award-Winning Journal of the Michigan State Medical Society

#### DIGEST OF PROCEEDINGS

Proceedings of the 1993 MSMS House of Delegates meeting, plus a variety of photos are featured in this special issue of Michigan Medicine. As the official digest of proceedings for the MSMS House of Delegates meeting, we hope you find this issue interesting and informative. This issue is dedicated to all physicians at all levels of organized medicine who have worked, and continue to work, to better the practice of medicine in this state.

### **MSMS HOUSE OF DELEGATES PROCEEDINGS**

#### CONTENTS

- **INAUGURAL ADDRESS**
- **HOUSE ACTION ON 1993 RESOLUTIONS**
- SPECIAL REPORTS 27
- 32 **EXAUGURAL ADDRESS**
- **AWARDS PRESENTATIONS**
- **FLECTIONS** 35
- SPECIAL MEMBERSHIPS 36
- 38 MSMS BOARD ACTION ITEMS
- **DELEGATES' RECORD OF ATTENDANCE** 43

#### REFERENCE COMMITTEE PERSONNEL

#### **DEPARTMENTS**

- **CLASSIFIEDS**
- **ADVERTISING INDEX** 55
- 56 PRESIDENT'S PAGE

#### In next month's issue:

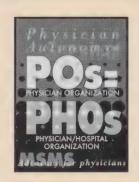
Physician Organizations, Physician-Hospital Organizations and Health Care Reform.

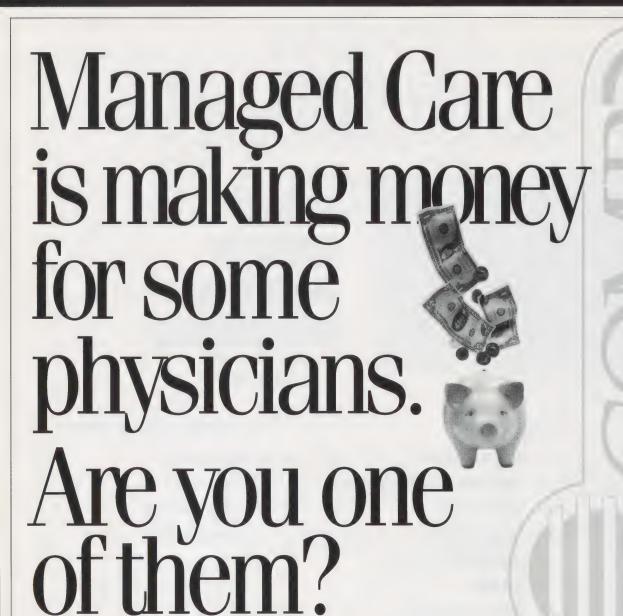
Cover illustration: By Robert L. Brent

House of Delegates photos by Pattrick Yockey.

#### COMING IN SEPTEMBER

The September 1993 issue of Michigan Medicine will provide an updated report on physician organizations and physician hospital organizations. A "must read" issue, the September Michigan Medicine report on POs/PHOs will include: an indepth article on MSMS' new Management and Organization Services (MOS); an informative report on models of POs and PHOs; a report from MSMS legal counsel on the legal aspects of POs and PHOs; a report on MSMS PO/PHO programs and activities to date; a summary of the MSMS PO/PHO Spring Conference; and the program for the upcoming MSMS/MPMLC PO/PHO Fall Conference. All this and more will be featured in this special issue of Michigan Medicine. Don't miss it!





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The Michigan State Medical Society Committee on Publications is the editorial board of Michigan Medicine and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Michigan Medicine reserves the right to accept or reject advertising copy. Products and services advertised in Michigan Medicine are neither endorsed nor warranteed by MSMS.

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Thomas Reardon, MD, an AMA Board of Trustees member from Portland, Oregon Jeff C. Goldsmith, PhD, a health care consultant and futurist from Brannockburn, Illinois Nathan Kaufman, a health care strategic planner from San Diego, California James G. Pitcavage, MD, a practicing pediatrian and organizer of two POs/PHOs from Sewickley, Pennsylvania

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Special Report



The 128th Annual Session of the Michigan State Medical Society House of Delegates was held April 30 - May 2, 1993 at the Ritz Carlton Hotel, Dearborn.

# MSMS HOUSE OF DELEGATES PROCEEDINGS

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# Inaugural Address



Newly-installed MSMS President Gilbert B. Bluhm, MD, (center) salutes MSMS Immediate Past President Thomas C. Payne, MD, (left) for his outstanding achievements during his presidency. He also congratulates and welcomes newly-elected MSMS President-Elect Jack L. Barry, MD (right).

# Michigan's Opportunity for Tomorrow

Gilbert B. Bluhm, MD

am honored to serve as the new president of MSMS. I believe all of us are in for a very challenging year. Clearly, the national rush to universal health coverage opens the most exciting challenge to come before us in several decades.

Our country is on the brink of a new social adventure. If prior major social plans for Social Security, Medicare and Medicaid are any guide, this new health program will be hastily implemented and poorly funded. These are the root problems that will consume much of our attention in the months ahead.

Cost of programs currently in place have brought us to this threshold. It is costs that will determine the quality and depth of care to be offered to the American public. We have all worked long and hard to build a quality health care program. None of us wants to see that effort compromised.

Physicians as prime health care managers have the task to reach out to the American public-our patients. We must clearly define for them their role in this effort and the bottom line impacts. The public has to address major cost issues which drive the way we practice medicine. Nearly a third of the costs in health care today result from poor lifestyle

habits. The other major health expenditure which is nearly a quarter of all expenses is related to the treatment of the terminally ill in hospital settings during the last 30 days of life.

We have a mandate to address these issues. To do that we have to do a better job of communicating...with our patients and with those whose efforts mold the environment in which we practice. I believe we may wish to take a leaf from Ross Perot's book and give the American public a basic primer on health, just as Perot did with "political science 101" last fall.

The physician's dilemma hasn't changed for almost a century when George Bernard Shaw characterized it succinctly: "The poor public makes a simple but unreasonable demand. They abhor illness and wish to be protected against it. But wish to be protected cheaply."

How do we help our patients, fellow citizens and our profession? We have the aptitude. We are experienced. But, it will be our attitude, not our aptitude, which will be crucial. Similar elements will be necessary that were used as we approached medical liability change. Our attitude was perseverance (two decades!). We dedicated the issue to the

best interest of our patients. We developed coalitions to help. We studied the facts. We learned the needs of our colleagues. We developed options. We prevailed!

Health care opportunities will require a similar approach. We will need to consider the differences within our family of physicians and other health providers. Our different vistas must be molded into effective policy and with unity modulate the issues of the betterment of patients and us. Our strength is the diversity of the membership. Working together to discuss and evaluate issues, ideals and events, we can produce a strong position to confront the anticipated change of health care reform. Buttress stated: "If truth can be derived, it is from the heat generated by the friction between free and friendly minds." Our task will be to keep us free and friendly!

What I've described is one of three activities I hope to promote during my tenure as MSMS president. The other two relate to a youth preventative health program and physician recruitment for a stronger MSMS.

#### Preventative health a key issue

Promotion of preventative health measures may provide longterm cost savings, but it is more important for quality of life. Already we have a head start! In cooperation with PBS station WTVS Channel 56 in Detroit, a series of health programs were developed and first aired throughout October 1992 for the "City for Youth." The program emphasized RESPECT, RELATIONSHIPS, RESPONSIBILITY, AND RISK MANAGEMENT. WTVS utilized its nationally recognized

nized "Club Connect" youth group to produce professionally written programs. Noteworthy was the technique used whereby youth health information was provided by youth peers. This made the information more appealing to a young audience.

From these programs were developed the Middle School health videotapes and teacher's manual. Besides the core financial support of WTVS, grants were obtained from a number of community organizations and foundations. More specifically monies were received for editing and reproduction of the videotapes from the Michigan Health Care Education and Research Foundation and BCBSM.

Our own MSMS Health Education Foundation approved a grant to duplicate and distribute the videos and teacher's manuals to every Middle School in every county of Michigan. In fact, the materials have already been mailed to all schools. Follow-up is needed to stimulate use. I urge you to contact the local middle schools where you live. And tell your PTA Board and friends the schools have them available. Put your prestige behind their use.

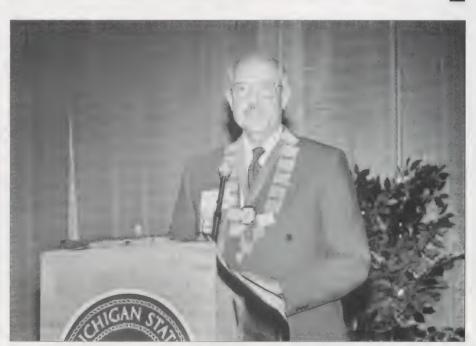
#### Physician recruitment vital

Physician recruitment remains vital to our organization. New members provide more diverse perspectives on the issues, increase clout locally and nationally as the numbers grow, contribute energy to accomplish goals, and distribute the cost of operations. There are too many non-member physicians who haven't understood or take for granted who it is that serves as their advocate, initiator and monitor for the profession. The best recruiters are you and me, one-on-one with our diligent, non-member colleagues. The opportunity beckons now. The necessity and time are right. I ask you to make this year one of our best for recruitment.

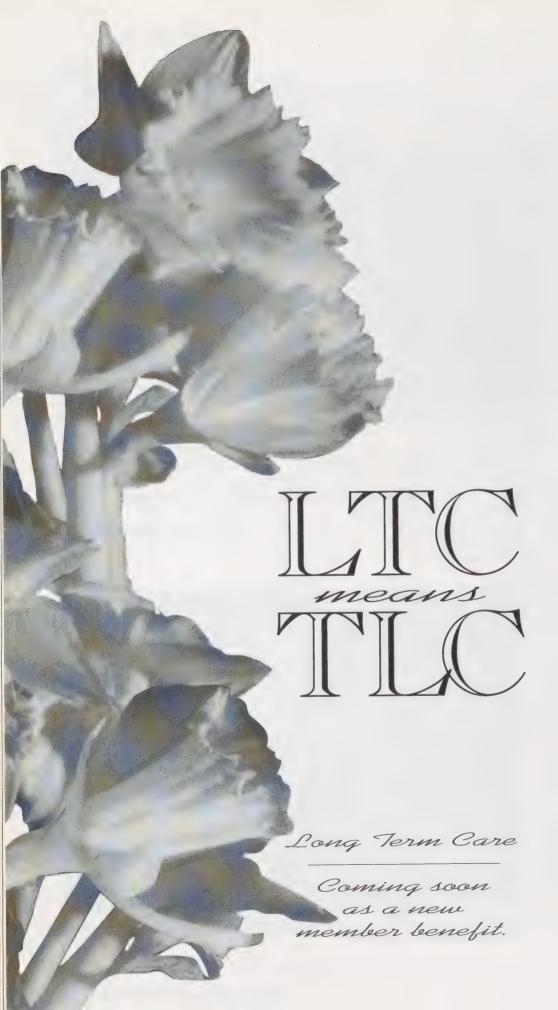
In closing, my fervent hope is that together we recognize the opportunities for our patients and us; we use wisdom to confront those opportunities that are without merit; we have courage to assist the opportunities that will benefit our patients; and in fairness we maintain unity to accomplish the task.

I am honored and eager to serve our membership as president of MSMS.

Thank you! And God Bless!



Newly-elected MSMS President Gilbert B. Bluhm, MD, stressed unity, membership and preventive health in his inaugural address May 1.





### House Considers 143 Resolutions



MSMS Speaker Robert D. Allaben, MD, (at the podium, far left), and MSMS Vice Speaker Gary D. Maynard, MD, (at the center podium), instruct members of the House from the dais during the MSMS House of Delegates meeting held at the Ritz Carlton Hotel, Dearborn.

#### 1-93A

Representation of the Chief Medical Executive of the State of Michigan in the MSMS House of Delegates.

Dawn E. Springer, MD, for the Ingham County Delegation on Behalf of Ronald Davis, MD, Michigan Department of Public Health

ADOPTED AS AMENDED.

RESOLVED: That MSMS amend its Constitution and Bylaws to add a seat in the House of Delegates for the Chief Medical Executive of the Michigan Department of Public Health as an ex-officio member, if an active member of MSMS.

#### 2-93A

Professional Activities of Representatives of MSMS Members.

Samir Ragheb, MD, Macomb County ADOPTED AS AMENDED.

RESOLVED: That MSMS ask candidates who are running for election or appointment to MSMS to provide biographical information, including their current professional activities, prior to the election.

#### 3-93A

Anti Smoking in Restaurants.

James B. Anderson, MD, Macomb
County

ADOPTED.

RESOLVED: That MSMS strive to pass legislation to prohibit smoking in all restaurants in the State of Michigan.

#### 4-93A

General Membership Annual Meeting. Samir Ragheb, MD, Macomb County REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That MSMS hold a general membership meeting annually to discuss topics of the time and inform the membership of the problems at hand and how the society is attempting to solve them; and be it further

RESOLVED: That MSMS not charge a registration fee for the general annual membership meeting.

#### 5-93A

Organ Donation.

Diane L. Morris, MD, for the Young Physicians Section

ADOPTED.

RESOLVED: That MSMS strongly oppose payment in any form to the donor, the donor's family members, or the donor's agents for organs used for transplant.

#### 6-93A

Managed Care Systems.

Diane L. Morris, MD, for the Young Physi-

cians Section

ADOPTED AS AMENDED.

RESOLVED: That MSMS initiate liaison with the medical directors of managed care systems; and be it further

RESOLVED: That MSMS enhance its products and services to include generic contract advice, legal and accounting services and education for physician members participating in managed care systems; and be it further

RESOLVED: That MSMS investigate what information is available on managed care systems from the AMA and different specialty societies.

#### 7-93A

**Practice Parameters.** 

Diane L. Morris, MD, for the Young Physicians Section

ADOPTED.

RESOLVED: That MSMS inform the Young Physicians Section of discussions regarding the basic principles of practice parameters, and provide educational material about practice parameters to the YPS Governing Council; and be it further RESOLVED: That MSMS involve the Young Physicians Section in the development of practice parameters in Michigan.

#### 8-93A

Physician Organizations and Physician Hospital Organizations.

Diane L. Morris, MD, for the Young Physicians Section

SUBSTITUTE RESOLUTION (IN LIEU OF 8-93A, 29-93A, 72-93A, 109-93A AND 127-93A). ADOPTED.

Continued on following page

RESOLVED: That MSMS continue to inform the membership concerning changes in the health care delivery system and the important role POs and PHOs may play in the new health care delivery system; and be it further

RESOLVED: That MSMS continue to inform physicians concerning the advisability of establishing a PO before establishing a PHO; and be it further

RESOLVED: That MSMS continue to expand its efforts to offer, through a subsidiary, legal assistance and other expert consulting services, on a fee-for-service basis, to assist the membership in establishing POs and PHOs.

#### 9-93A

Electronic Claims Submission.

Diane L. Morris, MD, for the Young Physicians Section

ADOPTED AS AMENDED.

RESOLVED: That MSMS investigate the various electronic media and software billing options being considered by third party carriers and provide information to the membership regarding these options.

#### 10-93A

Unfair Advertising.

Diane L. Morris, MD, for the Young Physicians Section

ADOPTED

RESOLVED: That MSMS establish a dialogue with other professionals and businesses to express deep concern about advertising practices that are potentially detrimental to the physician-patient relationship; and be it further

RESOLVED: That MSMS work to reverse the effects of advertising that is considered detrimental to physicians and patients wherever possible.

#### 11-93A

Gender-Neutral Language.

Diane L. Morris, MD, for the Young Physicians Section

ADOPTED AS AMENDED.

RESOLVED: That MSMS adopt a policy of gender-neutral language, to be incorporated into its bylaws, policies procedures, and publications, during the normal process of updating/printing documents.

#### 12-93A

Sexual Harassment Guidelines. Diane L. Morris, MD, for the Young Physicians Section ADOPTED AS AMENDED.

RESOLVED: That MSMS educate physicians of the importance of having guidelines on sexual harassment at their place of employment; and be it further

RESOLVED: That MSMS advocate that guidelines on sexual harassment be actively integrated into the medical work place; and be it further

RESOLVED: That MSMS publicize the availability of the free AMA publication, "Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures," and initiate an educational effort through existing communication channels to raise awareness of all physicians, residents and medical students concerning sexual harassment.

#### 13-93A

Cost of Hepatitis B Immunization.

Diane L. Morris, MD, for the Young Physicians Section

ADOPTED AS AMENDED.

RESOLVED: That MSMS investigate and inform the general membership of the apparent discrepancy in costs between pediatric and adult Hepatitis B immunizations on a per volume basis; and be it further

RESOLVED: That MSMS actively pursue all reasonable methods available to rectify any discrepancies between the cost per dose of adult and pediatric Hepatitis B Vaccine.

#### 14-93A

Ethical Treatment of Young Physicians. Diane L. Morris, MD, for the Young Physicians Section

ADOPTED AS AMENDED.

RESOLVED: That MSMS develop costeffective resources based on state of the art information available on buy/sell agreements between physicians; and be it further

RESOLVED: That MSMS encourage physicians to seek legal advice before signing contracts.

#### 15-93A

Academic Limited License Revisions. Diane L. Morris, MD, for the Young Physicians Section

REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That MSMS seek legislation to allow a physician licensed in another state to obtain a special, tempo-

rary Michigan license in cases where the out-of-state physician brings special expertise to work directly with a licensed Michigan physician for educational purposes.

#### 16-93A

Physician Support for State Wide Breast and Cervical Cancer Control Program for Eligible Women.

Dawn E. Springer, MD, Ingham County, for the Committee on Concerns of Women Physicians

ADOPTED AS AMENDED.

RESOLVED: That MSMS support the efforts of the Breast and Cervical Cancer Program, educate members regarding the existence of the program and urge the members to refer eligible patients to the program for screening as part of ongoing care.

#### 17-93A

Improving Physicians' Use of AMA Computer Databases.

W. Archibald Piper, MD, Genesee County ADOPTED.

RESOLVED: That the Michigan Delegation to the AMA request the AMA to provide a fuller computer database for fast easy retrieval by its members which would include a clipping service of pertinent recent articles and newsnotes from clinical literature as well as socio-economic information providing the current status of organized medicine's viewpoint on all breaking issues with the files to be updated on a daily basis; and be it further RESOLVED: That the Michigan Delegation to the AMA request the AMA to charge a subscription fee, if necessary, for physician members to obtain access to the AMA computer database.

#### 18-93A

Release of JAMA Articles.

W. Archibald Piper, MD, Genesee County
SUBSTITUTE RESOLUTION.
ADOPTED.

RESOLVED: That the Michigan Delegation to the AMA strongly encourage the AMA to advise *JAMA* to cease and desist from its current practice of prior release of the contents of its journals before receipt by members.

#### 19-93A

Guidelines for Quality Assurance Programs.

John A. Rupke, MD, for the Hospital Medical Staff Section

#### ADOPTED.

RESOLVED: That MSMS insist that any quality assurance program, whether by hospitals, third party payers or managed care programs, include physician input in the development of quality guidelines; and that each program must include due process for the physician indicating the right of appeal; and be it further

RESOLVED: That MSMS encourage medical staffs to work with their local third party carrier or managed care organization to share data, provide adequate safeguards for due process, develop proper protocols and assist in setting educational programs; and be it further RESOLVED: That MSMS work through its liaisons with Blue Cross Blue Shield of Michigan (BCBSM) and other third party payers to develop proper safeguards for pooling of data and due process so that "profiling" done by third party carriers and managed care organizations have some significance beyond the financial one.

#### 20-93A

National Credential Verification Service (NCVS) and the Michigan Professional Credential Verification Service (MPCVS). John A. Rupke, MD, for the Hospital Medical Staff Section

SUBSTITUTE RESOLUTION (IN LIEU OF 20-93A AND 49-93A). ADOPTED.

RESOLVED: That the Michigan Delegation to the AMA request the AMA to make the National Credentials Verification Service the repository acceptable to JCAHO, NCQA, AAPPO and other such accrediting bodies; and be it further

RESOLVED: That MSMS encourage its member physicians to participate in the Michigan Professional Credential Verification Service (MPCVS) and deposit their credentials within the National Credentials Verification Service; and be it further

RESOLVED: That MSMS widely publicize the availability and the merits of the Michigan Professional Credential Verification Service (MPCVS), as the exclusive distributor of the National Credential Verification Service (NCVS) in Michigan, in component society bulletins and *Michigan Medicine*.

#### 21-93A

Analysis of Administrative and Regulatory Costs of Providing Health Care.



Delegates lined up to debate "safe sex" as an appropriate medical term (Resolution 39-93A).

#### John A. Rupke, MD, for the Hospital Medical Staff Section

ADOPTED AS AMENDED.

RESOLVED: That the Michigan Delegation to the AMA request the AMA to distribute the analyses of administrative costs associated with government regulation, third party payer requirements, and the anticipated administrative costs of the soon to be proposed national health care reform package to providers, consumers, government officials and the media.

#### 22-93A

Physician Representation on Hospital Governing Boards.

John A. Rupke, MD, for the Hospital Medical Staff Section ADOPTED.

RESOLVED: That MSMS work with the Michigan Hospital Association to educate and encourage hospital administrations and governing bodies about the benefits of physician participation on governing boards; and be it further

RESOLVED: That MSMS foster a program to encourage members of the hospital medical staff to participate on their hospital governing boards and recommend in addition that elected chiefs of staff be voting members of their hospital governing boards.

#### 23-93A

Hospital In-Patient/Out Patient Testing for Human Immunodeficiency Virus HIV). John A. Rupke, MD, for the Hospital Medical Staff Section

ADOPTED.

RESOLVED: That MSMS seek legislation to implement the policy relating to informed consent to HIV testing adopted by the 1992 House of Delegates, which states, "MSMS supports the elimination of the informed consent requirements for HIV testing and the ability of physicians to perform HIV tests on patients as they feel it is appropriate for proper medical management of the patient."

#### 24-93A

Development of Guidelines for Medical Staff Bylaws.

John A. Rupke, MD, for the Hospital Medical Staff Section ADOPTED.

RESOLVED: That MSMS develop a set of model bylaws for use by medical staffs with attention to physician need, protection of rights, and prevention of intrusion into the practice of medicine, including sections relating to disabled physicians, disruptive physicians, sexual harassment, and due process.

Continued on page 15

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#### 25-93A

Making Medical Staff Bylaws A Legally Binding Contractual Agreement and Developing Guidelines for Relationships Between Hospital Medical Staffs and Hospital Boards.

John A. Rupke, MD, for the Hospital Medical Staff Section

ADOPTED AS AMENDED.

RESOLVED: That MSMS develop guidelines as to the proper division of responsibility and methods of communication between the hospital, the medical staff, and individual members regarding the legal obligations of the medical staff and the hospital board.

#### 26-93A

Tort Reform.

John A. Rupke, MD, for the Hospital Medical Staff Section

ADOPTED AS AMENDED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to continue its efforts with both Congress and directly with the Administration to give special emphasis on the financial consequences to society caused by defensive medical practices related to inequities in our tort system.

#### 27-93A

Preclude the Corporate Practice of Medicine.

John A. Rupke, MD, for the Hospital Medical Staff Section

SUBSTITUTE RESOLUTION (IN LIEU OF 27-93A, 43-93A AND 71-93A). ADOPTED. RESOLVED: That MSMS oppose the corporate practice of medicine either in the profit or nonprofit setting whereby the corporation employs physicians to practice medicine and bills for the services of the physicians; and be it further RESOLVED: That MSMS support the practice of medicine in a corporate structure solely under the Professional Service Corporation Act.

#### 28-93A

Prior Authorization Case Evaluation (PACE) Certification Process.

John A. Rupke, MD, for the Hospital Medical Staff Section

ADOPTED

RESOLVED: That the Michigan Delegation to the AMA request the AMA to investigate with all third party payers the possibility of modifying the PACE Certification process so that, especially in times when the physician determines the emergency transfer of patients, information can be submitted from the nursing unit by the appropriate hospital health care professional responsible for the care of the patient.

#### 29-93A

Physician Hospital Organizations (PHOs).

John A. Rupke, MD, for the Hospital Medical Staff Section

SUBSTITUTE RESOLUTION (IN LIEU OF 8-93A, 29-93A, 72-93A, 109-93A AND 127-93A). ADOPTED. SEE RESOLUTION 8-93A.

#### 30-93A

Physician and Physician Officer Compensation.

John A. Rupke, MD, for the Hospital Medical Staff Section

ADOPTED AS AMENDED.

RESOLVED: That MSMS encourage medical staffs to evaluate their committee structures and streamline committee activity; and be it further

RESOLVED: That MSMS encourage hospitals to provide funds to medical staff organizations so that physicians may be appropriately paid for their committee work; and be it further

RESOLVED: That MSMS research and prepare a report pertaining to the development of funds for medical staff activities and reimbursement for medical staff committee work.

#### 31-93A

Recognition of the American Academy of Disability Evaluating Physicians as a Recognized Specialty Society of the American Medical Association.

James K. Watkins, MD, Kent County DISAPPROVED.

#### 32-93A

Quantity-Based Physician Certification/ Recertification.

Robert S. Levine, MD, for the Oakland County Delegation

REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That MSMS policy be established opposing the use of the quantity of procedures performed within a given time span as a sole requirement for certification and/or recertification for performing given procedures; and be it further

RESOLVED: That MSMS work to remove any state or federal requirements

for physician certification and/or recertification soley based on the number of procedures performed within a given time span; and be it further

RESOLVED: That the Michigan Delegation to the AMA request the AMA to actively oppose and work for revocation of state or federal requirements for physician certification and/or recertification based on the number of procedures performed within a given time span.

#### 33-93A

Pre-Authorization.

Robert S. Levine, MD, for the Oakland
County Delegation
NO ACTION.

#### 34-93A

Immunizations.

Edward E. Elder, Jr., MD, for the Oakland County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS request that the Michigan Congressional Delegation support reauthorization of the National Vaccine Injury Compensation Act; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to support reauthorization of the Act.

#### 35-93A

Support for Physicians for a Fair Provider Plan (PF-PCP) Defense of Borsos Decision.

George B. Moser, MD, for the Oakland County Delegation

REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That MSMS support the efforts of PF-PCP; and be it further RESOLVED: That MSMS contribute \$25,000 to PF-PCP to defray expenses for past legal expenses; and be it further RESOLVED: That MSMS urge its individual members, component societies and specialty societies to support PF-PCP both through individual membership and contribution as well as membership and contribution by the component societies and specialty societies.

#### 36-93A

Preventive Medicine and Pain.

James A. Read, MD, for the Oakland
County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS promote an educational campaign to reduce the Continued on following page

prevalence of overweight persons and junk food malnutrition, to teach more effectively the range of diseases related to tobacco and alcohol, to reinforce discovery programs for chronic diseases, and to encourage exercise and other aspects of a healthy lifestyle.

#### 37-93A

**Educate Physicians About the Cost of Medical Care.** 

James A. Read, MD, for the Oakland County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS work with the Michigan Hospital Association to promote the idea that hospitals provide referring physicians current price lists for laboratory and x-ray procedures.

#### 38-93A

Raising the Cost of Cigarettes.

Murray B. Levin, MD, for the Oakland
County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS support legislation to significantly raise the tax on cigarettes and earmark the revenues to smoking related health issues.

#### 39-93A

"Safe Sex" a Deadly Misnomer. William D. Doebler, MD, Ottawa County ADOPTED AS AMENDED.

RESOLVED: That MSMS support the wording "less dangerous sex" when referring to sex using latex condoms in all educational and public health materials.

#### 40-93A

Assisted Suicide - A Felony.

William D. Doebler, MD, Ottawa County
NO ACTION.

#### 41-93A

Assisted Suicide.

Joseph E. Kincaid, MD, Kalamazoo
County

NO ACTION.

#### 42-93A

MSMS Policy on Air Quality and Hazardous Waste.

Terry E. Ragland, MD, for the Washtenaw County Delegation

SUBSTITUTE RESOLUTION (IN LIEU OF 42-93A AND 113-93A). ADOPTED AS AMENDED.

RESOLVED: That MSMS endorse the International Joint Commission's February, 1992 Report on Air Quality and urge that the principles contained therein be

applied throughout the Great Lakes Basin; and be it further

RESOLVED: That MSMS express serious concern with the construction of hazardous waste facilities based upon adverse health consequences from persistent toxic compounds and support the goal of "zero discharge" for toxic compounds; and be it further

RESOLVED: That this resolution be referred to the Board of Directors for the development of a process whereby county medical societies may request MSMS to assist or provide an independent review of environmental concerns within their counties before the next House of Delegates.

#### 43-93A

Preclude the Corporate Practice of Medicine.

Terry E. Ragland, MD, for the Washtenaw County Delegation

SUBSTITUTE RESOLUTION (IN LIEU OF 27-93A, 43-93A AND 71-93A). ADOPTED. SEE RESOLUTION 27-93A.

#### 44-93A

Medical Staff, Administration and Board Relationships.

Jack D. Gift, MD, Jackson County for Andrew J. Krapohl, MD NO ACTION.

#### 45-93A

Request the AMA to Survey Residency Review Committees Regarding Accreditation Problems.

Allan C. D. Brown, MD, for the International Medical Graduates Section

ADOPTED AS AMENDED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to seek information regarding residency programs experiencing accreditation problems which may be related to the proportion of IMGs in those programs.

#### 46-93A

Omnibus Physician Databank. Allan C. D. Brown, MD, for the International Medical Graduates Section

SUBSTITUTE RESOLUTION (IN LIEU OF 46-93A, 48-93A, 50-93A AND 52-93A) ADOPTED.

RESOLVED: That MSMS establish a mechanism to maintain data as needed to define the demographics of the physician population in the State of Michigan; and be it further

RESOLVED: That this data include, but not be limited to 1) the number of gradu-

ates from the residency programs in Michigan by program, including the number of IMG and LCME graduates in each; 2) the number of IMGs and other minorities involved in the resident selection process in each residency program; 3) the identification of physicians practicing in each county by specialty, and the percentage of IMGs and other minorities involved in such efforts; and 4) the identification of physicians by county involved in community-based activities identified as "free" care, together with the number of IMGs and other minorities involved in these activities.

#### 47-93A

It is Time for the AMA to Create an International Medical Graduate (IMG) Section.

Allan C. D. Brown, MD, for the International Medical Graduates Section ADOPTED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to create an IMG Section with representation in the AMA House of Delegates.

#### 48-93A

Study Number of IMGs Practicing in Smaller Communities.

Allan C. D. Brown, MD, for the International Medical Graduates Section
SUBSTITUTE RESOLUTION (IN LIEU OF
46-93A, 48-93A, 50-93A AND 52-93A).
ADOPTED. SEE RESOLUTION 46-93A.

#### 49-93A

Publicize National Credential Verification Service (NCVS) and the Michigan Professional Credential Verification Service (MPCVS).

Allan C. D. Brown, MD, for the International Medical Graduates Section
SUBSTITUTE RESOLUTION (IN LIEU OF 20-93A AND 49-93A). ADOPTED. SEE RESOLUTION 20-93A.

#### 50-93A

Increase IMG Involvement in Residency Selection and Other Hospital Committees.

Allan C. D. Brown, MD, for the International Medical Graduates Section SUBSTITUTE RESOLUTION (IN LIEU OF 46-93A, 48-93A, 50-93A AND 52-93A). ADOPTED. SEE RESOLUTION 46-93A.

#### 51-93A

Expand Coverage of Good Samaritan Law in Michigan.

Allan C. D. Brown, MD, for the International Medical Graduates Section
ADOPTED AS AMENDED.

RESOLVED: That MSMS continue to



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support Senate Bill 333 (Medical Malpractice Immunity: Uncompensated Care) which is currently pending in the House of Representatives.

#### 52-93A

Survey IMG Involvement in Community Activities.

Allan C. D. Brown, MD. for the International Medical Graduates Section SUBSTITUTE RESOLUTION (IN LIEU OF 46-93A, 48-93A, 50-93A AND 52-93A), ADOPTED. SEE RESOLUTION 46-93A.

#### 53-93A

**Increase Sexually Transmitted Diseases** (STDs) Counseling of Adolescents. Allan C. D. Brown, MD, for the International Medical Graduates Section ADOPTED.

RESOLVED: That MSMS encourage physicians, when counseling adolescents, including counseling on sexually transmitted diseases and AIDS in their interactions.

#### 54-93A

To Honor AppaRao Mukkamala, MD. Allan C. D. Brown, MD, for the International Medical Graduates Section ADOPTED.

RESOLVED: That MSMS recognize the efforts of AppaRao Mukkamala, MD, for his extraordinary leadership of the IMG Section.

#### 55-93A

Admission Requirements for IMGs for Post-Graduate Training.

Allan C. D. Brown, MD, for the International Medical Graduates Section REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to request residency program directors to use the scoring system for both IMGs and LCME graduates in selecting candidates for interviews beginning in 1994.

#### 56-93A

Denial of Selected Specialties for IMGs. Allan C. D. Brown, MD, for the International Medical Graduates Section NO ACTION.

#### 57-93A

**Advocacy Programs to Help Physicians** with Licensure and Employment Issues. Allan C. D. Brown, MD, for the International Medical Graduates Section.

ADOPTED AS AMENDED.

RESOLVED: That MSMS encourage component medical societies to establish a process to help solve problems physicians face in employment, licensing, hospital privileges, etc.

#### 58-93A

Establish IMG Recognition Day. Allan C. D. Brown, MD, for the International Medical Graduates Section DISAPPROVED.

#### 59-93A

Develop Non-Member Databank. Allan C. D. Brown, MD, for the International Medical Graduates Section REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That MSMS ititiate the establishment of a non-member databank on all physicians in Michigan.

#### 60-93A

Representation of the Medical Profes-

Allan C. D. Brown, MD, for the International Medical Graduates Section REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to take urgent action, to encourage all state medical societies to take urgent action to ensure that the varied and dissenting views of the WHOLE profession be taken into consideration when developing policy; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to request state medical societies to open their representative machineries to non-member physicians while limiting the tangible benefits of membership to member physicians only, thereby allowing organized medicine the reasonable claim to speak for ALL physicians in future negotiations.

#### 61-93A

Oral English Proficiency Exam. Allan C. D. Brown, MD, for the International Medical Graduates Section SUBSTITUTE RESOLUTION (IN LIEU OF 61-93A AND 62-93A). ADOPTED.

RESOLVED: That MSMS support House Bill 4295 and oppose Senate Bill 343.

#### 62-93A

Oral English Examination for Michigan Medical Licensure.

Allan C. D. Brown. MD. for the International Medical Graduates Section SUBSTITUTE RESOLUTION (IN LIEU OF 61-93A AND 62-93A). ADOPTED. SEE **RESOLUTION 61-93A.** 

#### 63-93A

The Study of Ethics and Laws Related to Medicine in Continuing Medical Educa-

George C. Hill, MD, Wavne County DISAPPROVED.

#### 64-93A

Physician and Public Support for Assisted Suicide. R. John Bradfield, MD, Wayne County NO ACTION.

#### 65-93A

MSMS Fee Schedule Policy. Gerald H. Mandell, MD, for the Wayne County Delegation

SUBSTITUTE RESOLUTION (IN LIEU OF 65-93A AND 75-93A), ADOPTED.

RESOLVED: That MSMS when appropriate, actively participate in the development of, or modification of, reimbursement methodologies and governmental fee schedules; and be it further

RESOLVED: That MSMS continue to oppose governmental fee schedules and reimbursement methodologies that were developed without appropriate physician input and/or which limit patient access to quality medical care and/or which unfairly reimburse physicians.

#### 66-93A

Review of Public Act 270. Fred W. Whitehouse, MD, for the Wayne County Delegation NO ACTION.

#### 67-93A

Lead Free Childcare Facilities. George C. Hill, MD, for the Wayne County Delegation

REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That MSMS seek legislation to include regulations, inspections and incentives (such as tax credits for appropriate lead abatement done in an approved manner) to ensure that all childcare facilities such as day care, nursery school and preschool have lead free environments in Michigan.

#### 68-93A

Michigan Madicina

MSMS Policy on Physician Terminating a Patient Relationship.

Joseph J. Weiss, MD, for the Wayne County Delegation.

REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That MSMS adopt a policy recommending a physician terminate the relationship with a patient (in an out-

Continued on page 19



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patient setting only) with the following procedures:

1) a letter be sent by certified mail, return receipt requested, that state the reasons for terminating the relationship and provide assistance in finding an alternative health care provider. (Either a list of physicians who could assume care with their office phone numbers, or the name and phone number of a physician referral source such as a hospital or the Wayne County Medical Society physician referral service), and

2) that the physician offer to continue care for the patient for up to 30 days from the receipt of the letter to allow time for the patient to find another health care provider and that the patient be informed that the physician will do so, and

3) that the medical records be made available to the physician assuming care in a timely fashion upon proper request of the patient; and be it further

RESOLVED: That MSMS will periodically educate its members about this recommended policy and provide a copy of this policy with a sample letter upon request.

#### 69-93A

Dealing with the Terminally III. Gerald H. Mandell, MD, for the Wayne County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS recommend and promote effective education in pain management and/or hospice care for physicians and medical students.

#### 70-93A

Oppose Legislation that Interferes with the Proper Patient/Physician Relationship.

Gerald H. Mandell, MD, for the Wayne County Delegation

ADOPTED.

RESOLVED: That MSMS work with the Legislature to see that any legislation passed in the area of assisted suicide does not interfere with the proper patient/physician relationship, particularly as such legislation relates to pain control and the terminally ill, so that physicians can continue to provide compassionate care to their patients in accordance with principles of medical care and ethics.

#### 71-93A

**Ban Corporate Practice of Medicine.** 

Joseph J. Weiss, MD, for the Wayne County Delegation

SUBSTITUTE RESOLUTION (IN LIEU OF 27-93A, 43-93A AND 71-93A). ADOPTED. SEE RESOLUTION 27-93A.

#### 72-93A

Physician Hospital Organization Pros and Cons.

Joseph J. Weiss, MD, for the Wayne County Delegation

SUBSTITUTE RESOLUTION (IN LIEU OF 8-93A, 29-93A, 72-93A 109-93A AND 127-93A). ADOPTED. SEE RESOLUTION 8-93A.

#### 73-93A

The Management of Pain.

George C. Hill, MD, for the Wayne County
Delegation
ADOPTED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to promote programs that foster the study of methods to more adequately manage pain.

#### 74-93A

Health Maintenance Organizations (HMOs) Billing Patterns.

George C. Hill, MD, for the Wayne County

**Delegation**ADOPTED AS AMENDED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to conduct a study of patterns of HMO premiums to determine whether the initial estimates are valid or are purposely understated to obtain a contract which will always be followed by escalating charges reflected in higher premiums and disseminate this information to the public.

#### 75-93A

MSMS Participation in Fee Schedules. Joseph J. Weiss, MD, for the Wayne County Delegation SUBSTITUTE RESOLUTION (IN LIEU OF 65-93A AND 75-93A). ADOPTED. SEE RESOLUTION 65-93A.

#### 76-93A

The Role of Allied Health Care Professionals in Medical Care.

Joseph J. Weiss, MD, for the Wayne County Delegation

SUBSTITUTE RESOLUTION. ADOPTED.

RESOLVED: That MSMS establish a task force to examine and report on the appropriateness of current arrangements and standards for allied health care under physician supervision.

#### 77-93A

Public Awareness of Treatment of the

Terminally III.

Joseph J. Weiss, MD, for the Wayne County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS continue and expand its campaign to bring to public attention the efforts by physicians to treat the terminally ill so that assisted suicide is not considered a necessary alternative to continued medical care.

#### 78-93A

Basic Health Benefit Plan for Michigan. Joseph J. Weiss, MD, for the Wayne County Delegation NO ACTION.

#### 79-93A

Economic Credentialing.

Joseph J. Weiss, MD, for the Wayne
County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS strongly oppose the use by hospitals of financial data as the sole reason for determining physician privileges; and be it further

RESOLVED: That MSMS urge the Michigan Hospital Association to discourage permitting its hospitals from using financial data as the sole reason for determining physician privileges; and be it further RESOLVED: That if any Michigan hospital is using financial data to determine physician privileges, MSMS inquire, upon request, whether the hospital is acting in a manner equitable to the physician and/or in violation of state laws.

#### 80-93A

Global Budgeting in Reimbursement Financing.

Joseph J. Weiss, MD, for the Wayne County Delegation ADOPTED.

RESOLVED: That MSMS monitor proposals in the development of global budgeting in reimbursement financing and circulate that information to its membership.

#### 81-93A

Poll Michigan Businesses Regarding Health Care Costs. Joseph J. Weiss, MD, for the Wayne County Delegation DISAPPROVED.

#### 82-93A

Clergy Involvement with the Terminally III.

Joseph J. Weiss, MD, for the Wayne

Continued on following page

#### County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS encourage the inclusion of the clergy in providing care for the terminally ill; and be it further RESOLVED: That MSMS encourage the inclusion of the clergy in meetings and discussions throughout the state to elicit their views and recommendations on the ethical and practical issues of care for the terminally ill.

#### 83-93A

Hospital and Hospice Guidelines in Care of the Terminally III.

Joseph J. Weiss, for the Wayne County Delegation

DISAPPROVED.

#### 84-93A

Appropriate Use of Diagnostic Facilities in Physician's Offices.

Samuel D. Indenbaum, MD, for the Wayne County Delegation

REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to seek legislation to support the appropriate use of diagnostic facilities in physicians' offices; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to oppose any legislation which would make it difficult for office based physicians to provide the necessary facilities to care for their patients in an efficient, convenient and appropriate way.

#### 85-93A

Universal Preschool Program.

Samuel D. Indenbaum, MD, for the
Wayne County Delegation
DISAPPROVED.

#### 86-93A

Home Alone.

Samuel D. Indenbaum, MD, for the Wayne County Delegation
ADOPTED AS AMENDED.

RESOLVED: That MSMS express its concern about children being left alone which is a very serious societal issue.

#### 87-93A

Self-Referral by Physicians.

Samuel D. Indenbaum, MD, for the
Wayne County Delegation
REFERRED TO THE BOARD FOR

STUDY.

RESOLVED: That MSMS support the

policy that all physicians in our state may utilize any cost-effective, quality diagnostic facility in an appropriate manner as permitted by third party coverage or patient affordability; and be it further RESOLVED: That the Michigan Delegation to the AMA ask the AMA to clarify its position to allow for and state clearly that it is ethical for physicians to use physician-owned diagnostic facilities, both in and out of the physician's office, in an appropriate manner, allowing for patients' right of choice.

#### 88-93A

Cooperation to Insure Patient Medication Safety.

Joseph J. Weiss, MD, for the Wayne County Delegation

SUBSTITUTE RESOLUTION (IN LIEU OF 88-93A, 118-93A AND 132-93A). ADOPTED.

RESOLVED: That MSMS work cooperatively with the Michigan Pharmacists Association to assure patient safety, confidentiality, and continuity of care; and be it further

RESOLVED: That MSMS request the Michigan Pharmacists Association to develop a policy on pharmacist's instructions to patients regarding medication interactions or side effects including the following statements:

A) Decreasing interrupting or discontinuing your medications can result in serious adverse health effects.

B) Do not modify your medication usage without notifying your doctor.

C) If you have any questions regarding your medication call your doctor.

#### 89-93A

Review of New England Journal of Medicine Article Regarding Michigan Physicians and Medicare.

Joseph J. Weiss, MD, for the Wayne County Delegation DISAPPROVED.

#### 90-93A

MSMS Investigate the Recruitment of Medicaid Participants by Health Maintenance Organizations (HMOs).

Joseph J. Weiss, MD, for the Wayne County Delegation

SUBSTITUTE RESOLUTION (IN LIEU OF 90-93A AND 106-93A). ADOPTED AS AMENDED

RESOLVED: That MSMS investigate if HMOs have undertaken improper recruitment of Medicaid participants for care and if their methods have placed the private physician and individual patients at a disadvantage in the Medicaid program; and be it further

RESOLVED: That MSMS take appropriate action to end such inappropriate practices if discovered.

#### 91-93A

Promoting the Health of the State's Youth.

Joseph J. Weiss, MD, for the Wayne County Delegation NO ACTION.

#### 92-93A

Partnerships in Managed Competition. Joseph J. Weiss, MD, for the Wayne County Delegation

ADOPTED.

RESOLVED: That MSMS initiate contacts with the emerging health insurers who are forming partnerships in anticipation of managed competition legislation for the purpose of developing relationships and dialogue similar to what now exists between MSMS and BCBSM.

#### 93-93A

Acceptance of Michigan-Based Health Insurance Plans Out-of-State. Joseph J. Weiss, MD, for the Wayne County Delegation DISAPPROVED.

#### 94-93A

Awareness of Issues in Health Care and Cost.

Joseph J. Weiss, MD, for the Wayne County Delegation NO ACTION.

#### 95-93A

Establishment of the Epidemiology of Elevated Blood Lead Levels in Michigan. George C. Hill, MD, for the Wayne County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS work with the Michigan Department of Public Health and the Michigan Chapter of the American Academy of Pediatrics to support measures to require that cases of elevated blood lead levels in Michigan be reported to the Michigan Department of Public Health.

#### 96-93A

Overpayment Letters from Blue Cross Blue Shield of Michigan (BCBSM). Joseph J. Weiss, MD, for the Wayne County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS meet with Medicare to revise overpayment letters to

contain more conciliatory language and reasonable intent than presently exists in these communications.

#### 97-93A

MSMS As a Bargaining Agent for Physicians.

Joseph J. Weiss, MD, for the Wayne County Delegation
DISAPPROVED.

#### 98-93A

Provider Tax.

Joseph J. Weiss, MD, for the Wayne
County Delegation
ADOPTED.

RESOLVED: That MSMS undertake a review of the implications of a provider tax in Michigan with particular attention to the effects on doctor flight and the redistribution of medical manpower that such a plan would evoke.

#### 99-93A

Assessment of Quality and Efficiency of Care.

Joseph J. Weiss, MD, for the Wayne County Delegation NO ACTION.

#### 100-93A

Fraudulent Expert Witnesses. Steven E. Olchowski, MD, for the Wayne County Delegation

ADOPTED AS AMENDED.

RESOLVED: That the Michigan Delegation to the AMA recommend that the AMA develop a system that will identify and expose the fraudulent expert witness and the expert witness who presents fraudulent testimony.

#### 101-93A

Required Fiscal Notes by Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Steven E. Olchowski, MD, for the Wayne County Delegation
ADOPTED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to pressure the JCAHO to include a fiscal note with any and all recommendations that have to be put in place in order to attain accreditation.

#### 102-93A

Arbitration Agreements.

Arthur A. Ulmer, MD, for the Wayne County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS seek legislation to modify the arbitration law in Michigan to allow a "one time" sign-up between physician and patient thus eliminating the annual renewal now required; and be it further

RESOLVED: That the arbitration agreement could be terminated by either party on 30 days notice, but not retroactive to any previous treatment or care; and be it further

RESOLVED: That the arbitration agreement be binding for all areas of care in both office and hospital; and be it further RESOLVED: That MSMS seek to change the present state law to include these modifications; and be it further

RESOLVED: That MSMS seek legislation to change the present state law to include arbitration as part of the health care contract.

#### 103-93A

Protocol for Physician's Responsibility to Monitor Patient Compliance with Medical Care.

Arthur A. Ulmer, MD, for the Wayne County Delegation

ADOPTED AS AMENDED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to develop risk management guidelines or protocols to limit and define physician responsibility to monitor patient compliance with medical care and orders.

#### 104-93A

Legislation to Disallow the Use of "Hold Harmless" Clauses in Managed Care Programs.

Joseph J. Weiss, MD, for the Wayne County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS oppose the use of "hold harmless" and/or indemnification clauses in managed care programs.

#### 105-93A

Legislation for Sterilization of Women Under Age Twenty-One.

Joseph J. Weiss, MD, for the Wayne County Delegation

ADOPTED AS AMENDED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to seek legislation that would permit payment by government programs for voluntary sterilization of adults 18 years and over.

#### 106-93A

Door-to-Door Canvassing for Managed Care Networks. Joseph J. Weiss, MD, for the Wayne County Delegation
SUBSTITUTE RESOLUTION (IN LIEU OF
90-93A AND 106-93A). ADOPTED AS
AMENDED. SEE RESOLUTION 90-93A.

#### 107-93A

Infertility Insurance Coverage.

Dorothy Kahkonen, MD, for the Wayne
County Delegation
DISAPPROVED.

#### 108-93A

Development of Integrated Electronic Information System.

Joseph J. Weiss, MD, for the Wayne County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS evaluate the possibility of developing a community electronic network in Michigan.

#### 109-93A

Evaluation of Physician Management Organizations (PMOs).

Joseph J. Weiss, MD, for the Wayne County Delegation

SUBSTITUTE RESOLUTION (IN LIEU OF 8-93A, 29-93A, 72-93A, 109-93A AND 127-93A) ADOPTED. SEE RESOLUTION 8-93A.

#### 110-93A

Physician Reimbursement by Health Maintenance Organizations (HMOs). Joseph M. Beals, MD, Wayne County DISAPPROVED.

#### 111-93A

MSMS Endorsement of Great Lakes Quality Initiative.

Allen F. Turcke, MD, Genesee County ADOPTED.

RESOLVED: That MSMS endorse the Great Lakes Water Quality Initiative as an important first step in improving Great Lakes water quality; and be it further RESOLVED: That MSMS urge the Governor and the legislature to implement the proposals of the Great Lakes Water Quality Initiative.

#### 112-93A

Television—Safeguard the Public Interest. *Edgar P. Balcueva, MD, Saginaw County* NO ACTION.

#### 113-93A

Endorsement of International Joint Commission's Position on Air Quality. Allen F. Turcke, MD, Genesee County SUBSTITUTE RESOLUTION (IN LIEU OF 42-93A AND 113-93A). ADOPTED AS AMENDED. SEE RESOLUTION 42-93A.

Continued on page 23

August 1993

#### HEALTHY RELATIONSHIPS



"He's done a fantastic job with my patients, and he keeps me informed about their progress every step of the way."

Dr. Cesar Casten Family Practice, Standish, MI

"The St. Luke's Specialist Referral Network introduced me to Dr. deBari. I work closely with a local foster home in our area that houses many individuals with paraplegia and other disabilities, and I frequently send these patients to Dr. deBari for the more specialized orthopedic care they need. It's a great relationship. I benefit. Dr. deBari benefits. And, of course, our patients benefit most of all."



Dr. Anthony deBari, Orthopedic Surgery St. Luke's Specialist Referral Network, Saginaw, MI

"I've only been practicing in this area for three years, and St. Luke's Specialist Referral Network has been very helpful in marketing my practice. I've had many doctors refer patients to me and consult with me about a patient. I'm more than happy to do that. After all, that's what the Specialist Referral Network is all about. Physicians helping physicians."

### SPECIALIST REFERRAL NETWORK

It's a simple idea. Rural physicians call St. Luke's Specialist Referral Network when they need the advice or services of a specialist. The Network contacts the appropriate specialist, arranges a phone consultation or makes a referral appointment, then calls the rural physician with the information. No hassles No waiting. A simple idea. And it's working. When a healthy relationship with one of our Saginaw area specialists can help you and your patient, call the Specialist Referral Network at 1-800-541-3939. St. Luke's Specialist Referral Network. Building healthy relationships among rural physicians, area specialists and their patients.



#### 114-93A

Support Development of a Statewide Policy on Storage of High Level Radioactive Waste.

Allen F. Turcke, MD, Genesee County ADOPTED AS AMENDED.

RESOLVED: That MSMS support development of a statewide policy on storage of high level radioactive waste.

#### 115-93A

Scope of Practice Legislation. Patrick J. Droste, MD, Kent County ADOPTED AS AMENDED.

RESOLVED: That MSMS examine the Arizona statute that defines the process which regulated health care professionals must complete before any legislation to expand their scope of practice is introduced, and if appropriate, seek introduction of similar legislation in Michigan.

#### 116-93A

Casino Gambling in the City of Detroit. Joseph M. Beals, MD, for the Wayne County Delegation DISAPPROVED.

#### 117-93A

Patient Support.

Robert S. Levine, MD, Oakland County
REFERRED TO THE BOARD FOR
STUDY.

RESOLVED: That MSMS work with the Michigan Association of Osteopathic Physicians and Surgeons and the Insurance Commissioner to develop an outside impartial review board for patients to appeal decisions of an insurance carrier that prospectively deny procedures and/or treatments which patients and/or their physicians feel are necessary; and be it further

RESOLVED: That MSMS work with the Michigan Association of Osteopathic Physicians and Surgeons and the Insurance Commissioner to develop an outside impartial review board to make a final decision that would be binding on both the third party carrier and the patient whether a procedure and/or treatment would be allowed for a given patient

#### 118-93A

Pharmacy Reporting.

Robert S. Levine, MD, Oakland County
SUBSTITUTE RESOLUTION (IN LIEU OF
88-93A, 118-93A AND 132-93A).

ADOPTED. SEE RESOLUTION 88-93A.

#### 119-93A

MSMS Teleconferencing Capacity. Carol A. Krieg, MD, Delta County ADOPTED.

RESOLVED: That MSMS reserve up to \$10,000 to implement the use of modern telecommunications technology to effectively and efficiently increase membership participation in all MSMS activities; and be it further

RESOLVED: That MSMS implement these new technologies through use of these new technologies beginning no later than September, 1993; and be it further

RESOLVED: That MSMS communicate the availability of this program to its members.

#### 120-93A

Opposition to House Bill 4156.

Floyd G. Goodman, MD, Ingham County REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That MSMS join the effort to stop House Bill 4156 from taking effect and support the referendum; and be it further

RESOLVED: That MSMS assign the highest priority to ensuring that the people of Michigan can be secure in knowing that they will continue to have access to the highest quality medical care for auto accident injuries and that auto insurance coverage will provide adequate reimbursement for that care without restricting freedom of choice or limiting medical benefits for necessary care.

#### 121-93A

Legislation to Define the Practice of Medicine.

Floyd G. Goodman, MD, Ingham County REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That MSMS seek legislation to define the practice of medicine as the science and art of medical care through the prevention or diagnosis and treatment of symptoms, conditions or diseases for the human mind or body systems to include, but not be limited to the following:

- 1. evaluation and investigation through laboratory, radiological, physical or chemical testing, and
- 2. analysis and interpretation of data resulting from medical testing and examination for the purpose of diagnosing or

ruling out diseases or conditions of the human mind or body, and

3. selection and application of reasonable and appropriate treatments or therapies, in conjunction with advising and securing the informed consent of the patient or patient's legal guardian, and

4. maintaining the integrity, privacy and confidentiality of the patient/physician relationship at all times, and

5. determining medical necessity as to the appropriateness of diagnostic tests, treatment, therapy or hospital confinement; and be it further

RESOLVED: That MSMS seek legislation to provide that an insurer, a health care corporation or a government agency may not interfere with the patient/physician relationship by determining medical necessity. If such an entity attempts to do so, it shall be subject to the loss of its licensure and/or other significant penalties and fines, and will be subject to medical liability for any undesirable outcome resulting directly or indirectly from such interference.

#### 122-93A

Sever Financial Relationships Between MSMS and Blue Cross Blue Shield of Michigan (BCBSM).

Floyd G. Goodman, MD, Ingham County (BOARD REPORT #8 ADOPTED IN LIEU OF RESOLUTION 122-93A). ADOPTED. SEE BOARD REPORT #8.

#### 123-93A

Opposed Managed Competition.

Jeffrey C. Custer, MD, Branch County
and Andrea D. Gelzer, MD, Hillsdale
County
NO ACTION.

#### 124-93A

Education of Students on the Hazards of Ultraviolet Radiation (Tanning Rays). Barbara M. Mathes, MD, Michigan Dermatological Society
ADOPTED.

RESOLVED: That MSMS work with the State Board of Education to include in the curriculum appropriate information for teachers to educate their students about the hazards of ultraviolet radiation; and be it further

RESOLVED: That MSMS seek legislation to make tanning parlors less dangerous via state laws and city ordinances; and be it further

Continued on following page

RESOLVED: That the Michigan Delegation to the AMA introduce a similar resolution to the AMA House of Delegates.

#### 125-93A

HIV Testing for Women in Michigan.

Domenic R. Federico, MD, Michigan Section of American College of Obstetrics and Gynecology (ACOG)

ADOPTED AS AMENDED.

RESOLVED: That MSMS ask the Michigan Department of Public Health to continue to inform the public about the risks of perinatal HIV transmission and to strongly recommend HIV testing for all pregnant women and those considering pregnancy.

#### 126-93A

Reflective Strips on Railroad Cars. Edgar P. Balcueva, MD, Saginaw County NO ACTION.

#### 127-93A

MSMS Champion the Role of Physicians in Directing Physician Hospital Organizations.

Andrea D. Gelzer, MD, Hillsdale County and Jeffrey C. Custer, MD, Branch County

SUBSTITUTE RESOLUTION (IN LIEU OF 8-93A, 29-93A, 72-93A, 109-93A AND 127-93A) ADOPTED. SEE RESOLUTION 8-93A.

#### 128-93A

Involuntary HIV Testing.

Timothy B. Aiken, MD, St. Clair County
NO ACTION.

#### 129-93A

HIV Health Care Worker Assistance. Timothy B. Aiken, MD, St. Clair County ADOPTED AS AMENDED.

RESOLVED: That MSMS develop recommendations for the HIV infected worker, specifically in the area of adequate insurance prior to the development of disability, and including, but not limited to, job retraining.

#### 130-93A

Malpractice and Maloccurrence. *Timothy B. Aiken, MD, St. Clair County* ADOPTED AS AMENDED.

RESOLVED: That MSMS work in conjunction with the American Medical Association to develop a proposal to make a legal distinction between malpractice and maloccurrence and that the new more strict standard of malpractice be applied in malpractice litigation.

#### 131-93A

Physician Input for National Health Care Program.

Timothy B. Aiken, MD, St. Clair County ADOPTED.

RESOLVED: That MSMS support the principle of physician input at all levels in the development of any national health care programs.

#### 132-93A

Pharmacist Instructions to Patients. Jack D. Gift, MD, Jackson County for James W. Wilkins, Jr., MD SUBSTITUTE RESOLUTION (IN LIEU OF 88-93A, 118-93A AND 132-93A). ADOPTED. SEE RESOLUTION 88-93A.

#### 133-93A

Change in Tort Law to Redress the Decision of the Michigan Supreme Court in the Case of Falcon vs. Memorial Hospital. David J. Lieberman, MD, for the Monroe County Delegation
NO ACTION.

#### 134-93A

Gratitude to Willys F. Mueller, Jr., MD.

Allen F. Turcke, MD, for the Genesee

County Delegation

ADOPTED.

RESOLVED: That MSMS recognize the efforts of Willys F. Mueller, Jr., MD, on behalf of HIV positive patients and their families.

#### 135-93A

Rapid Response by Blue Cross Blue Shield of Michigan (BCBSM) to Lost Checks.

Samuel D. Indenbaum, MD, Wayne County

ADOPTED AS AMENDED.

RESOLVED: That MSMS request from third party carriers that they develop a rapid turnaround system which allows a lost check to be re-issued within 30 days.

#### 136-93A

Reimbursement of Interpreter Services. Samuel D. Indenbaum, MD, Wayne County

ADOPTED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to seek change in the American with Disabilities Act to place the obligation of the cost of providing an interpreter by a physician on patients with insurance reimbursement.

#### 137-93A

Equal Medical Coverage for Medicare and Medicaid.

Samuel D. Indenbaum, MD, Wayne County

NO ACTION.

#### 138-93A

Abolish Triplicate Prescription Program. William D. Doebler, MD, Ottawa County NO ACTION.

#### 139-93A

Endorsement of Commission of Office Laboratory Accreditation (COLA). Catherine A. Upton, MD, Michigan Society of Internal Medicine

ADOPTED AS AMENDED.

RESOLVED: That MSMS continue to publicize and provide information to physicians concerning the accreditation program for office laboratories of the Commission on Office Laboratory Accreditation (COLA).

#### 140-93A

Third Party Reimbursement to Internists for Hospitalized Patients. *Joseph M. Beals, MD, Wayne County* 

ADOPTED AS AMENDED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to establish a policy recommending reimbursement be allowed to both a primary care physician and a specialist when providing concurrent care for the same diagnosis.

#### 141-93A

Violence in the Health Care Setting. Terry E. Ragland, MD, for the Washtenaw County Medical Society NOT ACCEPTED AS A LATE RESOLU-TION.

#### 142-93A

Prevent Blue Cross Blue Shield of Michigan (BCBSM) Purchase of Accident Fund (Defeat Senate Bill 568).

Floyd G. Goodman, MD, Ingham County ADOPTED AS AMENDED.

RESOLVED: That MSMS oppose SB 568 and advise members of the status of this legislation.

#### 143-93A

Concerns That Blue Cross Blue Shield of Michigan Develops Programs Without Consultation.

Allen F. Turcke, MD, on behalf of the Genesee County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS express its concern that BCBSM continues to develop programs without appropriate consultation with MSMS through its committee process; and be it further

RESOLVED: That MSMS express concern about the BCBSM Community Care Partnership Program.



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# Breast of chicken



# Today's Pork: Compare it to chicken for a healthy surprise

You may not have considered pork to be a healthy choice for your patients on fat-modified diets. But today's fresh pork compares surprisingly well to chicken in total fat, saturated fat, cholesterol, and calories. 1.2\*

### Compare pork with chicken<sup>1,2\*</sup>

| I   |          |       |                          |             |
|---|----------|-------|--------------------------|-------------|
|   | Calories |       | Saturated<br>Fatty Acids | Cholesterol |
| Chicken Breast,<br>skinless                   | 140      | 3.0 g | 0.9 g                    | 72 mg       |
| Pork Tenderloin,<br>trimmed                   | 139      | 4.1 g | 1.4 g                    | 67 mg       |
| Pork Top Loin<br>Roast (boneless),<br>trimmed | 165      | 6.1 g | 2.2 g                    | 66 mg       |
| Center Loin Chop, trimmed                     | 172      | 6.9 g | 2.5 g                    | 70 mg       |
| Chicken Thigh, skinless                       | 178      | 9.2 g | 2.6 g                    | 81 mg       |

\*Table refers to 3-oz, cooked servings.

# Best of pork



# New study: Pork is now 31% leaner

Pork is leaner today because of significant changes made in breeding and feeding techniques.<sup>1</sup> According to new 1992 official USDA data, fresh pork sold today contains an average of 31% less fat after cooking and trimming than the same pork cuts reported in 1983.<sup>1</sup>

Today's pork fits well within the dietary guidelines recommended by both the American Heart Association and the National Cholesterol Education Program. Here's some advice to help patients on low-fat diets enjoy the variety, extra taste, and versatility of pork:

- Choose the leanest cuts. Shop for cuts with "loin" in the name.
- Trim away any visible fat.
- Keep portions moderate (about 3 oz, cooked).
- Prepare by broiling or roasting, and avoid additional fat in preparation.
- 1. US Dept of Agriculture. Composition of Foods: Pork Products, 1992. Agricultural handbook 8-10.
- 2. US Dept of Agriculture. Composition of Foods: Poultry Products, 1979. Agricultural handbook 8-5.



The Other White Meat®



### Reports to the House

Following are excerpts of reports given by the chairs or presidents of these groups: the Michigan Delegation to the AMA; the MSMS Auxiliary; the MSMS Group Insurance Trust; Physician Service Group, Inc.; Abbott Press, Inc.; the Physician Review Organization of Michigan; and the Health Education Foundation.

#### Report of the Michigan Delegation to the AMA

Billy Ben Baumann, MD, Chair

The 22-member Michigan Delegation to the AMA is concentrating its activities this year on reelecting Frank B. Walker, MD, to a full three-year term on the AMA Board of Trustees.

Highlights of the past year included the following: The Delegation successfully campaigned for Doctor Walker, who was reelected to the AMA Board of Trustees for a one-year, unexpired term; and for Susan H. Adelman, MD, who won a three-year term on the AMA Council of Medical Service. Tama D. Abel, MD, was elected alternate delegate by the AMA Young Physicians Section, and also was named to the AMA Women's Advisory Council. Nine Michigan physicians, including MSMS President-elect Gilbert B. Bluhm, MD, were honored for their membership outreach efforts. The AMA House of Delegates passed a memorial resolution for the late George D. Slagle, MD, Battle Creek, who served as AMA vice president in 1975-76. Rhoda M. Powsner, MD, took the seat of former Delegation Member Donald K. Crandall, MD, who resigned just prior to the meeting.

Ten of 12 resolutions carried by the Michigan Delegation to the AMA Annual Meeting were passed in one form or another, while the other two were referred to the AMA Board. Five of the nine Michigan resolutions introduced at the Interim Meeting were adopted in some form.

## **Report of the Michigan State Medical Society Auxiliary**Beverly J. Jensen, President

MSMS-A sponsored three courses on domestic violence at the MSMS Annual Scientific Meeting in November. These courses presented an opportunity for physicians and spouses alike to learn about child, spouse, and elder abuse. MSMS-A members are also represented on the MSMS Task Force on Domestic Violence. County medical society auxiliaries are actively involved with the medical society counterparts by serving on local and community shelter boards and task forces.

MSMS-A members continued their legislative activity during 1992 by working for a medical liability reform package. Auxiliary members vigorously lobbied by calling and writing their senators and representatives in regards to this and other medically related issues.

In June, the MSMS-A Delegation to the American Medical Association Auxiliary voted overwhelmingly to approve the name change from "Auxiliary" to "Alliance." MSMS-A members will be presented the same resolution at our House of

Delegates next week. If approved, our new name and tag line will read "Michigan State Medical Society Alliance, physicians' spouses caring today for a healthier tomorrow."

Our members raised this year over \$27,000 for AMA-ERF, as well as thousands of dollars generated by counties for local and community projects. At our House of Delegates, we will present checks to the medical school deans in amounts totalling over \$46,000.

We are no longer a "tea and crumpet" organization. We are rightfully taking our places along side our physician spouses as an ally in the "fight" for improved medical care.

#### Report of the MSMS Group Insurance Trust

B. David Wilson, MD, Chair

The Group Insurance Trust (GIT) serves the MSMS membership

through the marketing and administration of insurance programs. The largest responsibility of the Group Insurance Trust continues to be the Blue Cross Blue Shield Health Insurance Program. During the last year, this program has seen steady growth in both individual products for physicians, as well as enrollments by groups. The combined premium from the health insurance program is approaching \$25 million. This represents a significant member benefit and the Group Insurance Trustees are committed to constantly reviewing the product with Blue Cross Blue Shield to find ways of providing better benefits at reduced rates.

As part of its commitment to the MSMS membership, the Trustees commissioned a study by Plante & Moran to investigate the administrative costs of the Blue Cross Blue Shield program. This report indicates there have been significant increases in these costs and the Trustees have begun discussions with Blue Cross Blue Shield regarding how to manage these increases. Additionally, the Trustees continue to review with Blue Cross, the possibility of MSMS assuming more administration of the program in order to reduce costs and provide better benefits in a more efficient manner.

Along with the Blue Cross Blue Shield program, the Trust is responsible for the MSMS-sponsored Delta Dental Insurance Program. This program has seen significant growth since it was introduced four years ago and currently has premiums of over \$1 million. The program has not had a rate increase for the last three years. The Trustees are currently reviewing additional options for the dental insurance to provide a larger selection of benefit and premium options for the membership.

The GIT has approved a long-term care product to be available to the membership in 1993. Additionally, the Trust is responsible for marketing the AMA-sponsored HIV program and an exciting new program for medical students. The Medical Student Program will be provided through medical schools and is a package of health, life, and disability insurance. GIT is

Continued on following page

very optimistic the medical schools in Michigan will adopt this program.

#### Annual Report of Physician Service Group, Inc.

Billy Ben Baumann, MD, President

The Physician Service Group, Inc. (PSG) continues its mission of providing high quality service to the MSMS members and revenue to the Michigan State Medical Society. Over 10,000 physicians are now receiving services through specialty societies administered by PSG. Approximately 12,000 physicians use various PSG endorsed services and 9,000 physicians, their families and employees use the services of the MSMS insurance programs administered by PSG.

PSG's professional management services to 14 medical specialty organizations includes the planning of approximately 200 meetings per year, both for the leadership of the organization, as well as general education programs for their membership. MSMS has made a major commitment to work closely with the specialty societies and to draw on their expertise and leadership in developing the overall MSMS program. The PSG administrative services of the specialty societies provide a vital link between these organizations and the programs of MSMS. In return, the specialty societies have provided significant contributions to the Annual Scientific Meeting and have shown significant willingness to share

information and coordinate activities in the area of reimbursement policy and legislative activities.

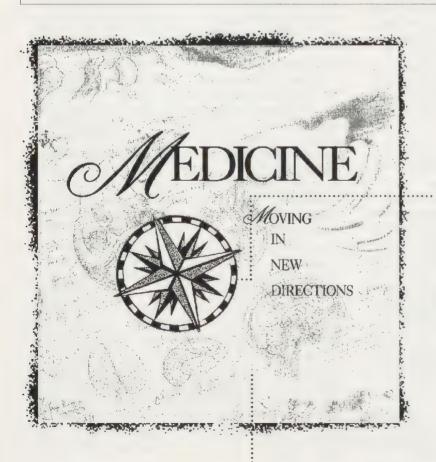
Under contract to the Group Insurance Trust, PSG administers the MSMS health and dental insurance programs. PSG's customer service representatives receive approximately 12,000 calls per year, resolving problems and issues with insurance programs in a timely manner. It is expected this area will grow with the addition of other insurance programs and activities. PSG's Endorsed Service Program continues to be used by a significant number of physicians. The products and services identified and endorsed by the Medical Society are well received by the membership. In addition, MSMS receives substantial contributions from these organizations through advertising revenue as well as attendance at meetings and support for the Health Education Foundation. The relationship with each one of these organizations continues to be excellent. Each organization has shown a willingness to cooperate with MSMS and its programs and assist with MSMS' overall mission to serve physicians.

PSG will continue to review new products for endorsement and focus on promotion to inform physicians of PSG services.

#### **Report of Abbott Press**

Billy Ben Baumann, MD, President

Abbott Press completed its first year of operation December



Michigan State Medical Society

1993 ANNUAL SCIENTIFIC MEETING
November 9, 10 & 11, 1993
Westin Hotel, Renaissance Center, Detroit



1, 1992, with a total revenue of \$703,353 against expenses of \$849,850. This leaves an expense over revenue of \$146,497 for the first year. The loss from Abbott Press will be used to offset taxes on the approximate \$100,000 profit made by PSG and PROM.

A significant portion of Abbott's loss was incurred during the first six months of operation as its sales and activities were in a start-up phase. The last six months of operations have shown a significant increase in revenue as well as a stabilizing of expenses. Many one-time expenses were incurred to begin operation and will not recur in future years.

Abbott Press is looking forward to expanding into new market areas in 1993. The first of these will be the development of marketing forms to physicians. This activity has potential to be very profitable with a minimum of expense associated with it. Abbott Press will act as a broker for companies already printing large volumes of forms. Using this arrangement, Abbott Press can be extremely competitive while incurring a minimum of expense.

During 1992, Abbott Press gained extensive experience providing for the printing needs of physicians moving their offices or creating new medical groups. Additionally, Abbott will continue to pursue the Lansing association market as well as the county medical societies and hospitals. All of these markets have proven to be very responsive and profitable.

Abbott Press has begun to address the issue of its operational expenses by having a consultant review its current accounting activities in order to design a system ensuring timely and accurate information regarding costs.

#### Health Education Foundation

Robert E. Paxton, MD, President

The Health Education Foundation continues to work towards its goal of increasing the physician awareness level of the Foundation, its activities and its mission and thereby increasing the contributions made to the Foundation.

As briefly as possible, let me address specific items regarding the past year and the future of the Foundation.

- 1. Financial Matters: The Foundation continues to maintain responsibility for its own investment portfolio and those of the Danto Memorial Fund, Bruce Fellowship Fund, and the Impaired Physician Loan Fund. Mr. Tom McGann, Vice President of Comerica Bank provides advice and support to the Foundation regarding our investment portfolios.
- 2. Grant Activity: The Board of Trustees awarded the following grants in 1992:
- Michigan Health Council support of \$5,000 for publication of a Health Careers Manual
- Michigan 4-H Foundation \$5,000 over two years for support Continued on following page

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of the Healthy Plants section of the Children's Garden.

- Webberville High School \$3,500 for the purchase of CPR mannequins to teach CPR to junior and high schoolior and high school students.
- Respite Volunteer Association \$2,400 for training of respite volunteers.
- Council of MI Foundations Michigan AIDS Fund \$2,000
- 3. *Impaired Physician Loan Fund:* No loans were made in 1992. Outstanding loans are being scrutinized and tracked on a regular basis. As always, the primary purpose of the impaired physician loan fund is to provide monies to assist with rehabilitation, not personal, expenses.
- 4. Fundraising Activities: The Foundation represents a remarkable opportunity for the medical profession to accomplish non-self serving, altruistic community service goals, but only if the corpus of the Foundation, attains a size to make the Foundation efforts truly productive. Fundraising is therefore an essential function and could be termed the "life-blood" of the Foundation. A letter requesting financial support was mailed to each MSMS member in October resulting in approximately \$4,000. A follow-up letter is being planned for spring of this year. We are very appreciative of the member's personal support to their Foundation. Their support is the most important of all if we are to have true success in our fundraising efforts.

The first annual MSMS Health Education Foundation family outing was held in 1992 realizing a profit of \$375 for the Foundation. The attendance at this fundraiser was less than hoped for, but was very appreciated by those attending. The Second Annual Family Outing is scheduled for August 13-15, 1993, at Crystal Mountain Resort, with proceeds going to the Foundation. A silent auction to be held at the 1993 MSMS House of Delegates is being planned. Several Michigan resorts have been very generous with their contributions towards our efforts. Another cruise or Club Med raffle is being planned for the fall of 1993. Ongoing discussions with county medical societies and the MSMS Auxiliary for joint fundraising efforts are taking place, as well as, planned giving efforts on behalf of the Foundation.

# Report of the Physician Review Organization of Michigan, Inc.

Robert C. Prophater, Sr., MD, President

The Physician's Review Organization of Michigan (PROM) Board of Directors view the major role of PROM as maintaining the highest integrity as an organization for independent objective third party review services.

Emphasis in 1993 will be on improving the awareness of PROM to hospitals, third party payers, HMOs, insurance carriers and other health groups, to inform them of the services

# Are Insurance Companies Sitting On Your Money?

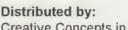


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available from PROM. PROM is often confused with MPRO.

The Board of Directors approved the hiring of a part-time medical director in April 1992. The initial charge of the medical director was to recommend steps to strengthen the quality of the review process. This led to quality improvements in review for third party payers, expansion of hospital review and credentialing activities.

PROM has completed more than 21,000 medical reviews, providing appellate services to Blue Cross and Blue Shield of Michigan, other insurers, HMOs, and hospitals. PROM staff meets regularly with BCBSM utilization review staff to jointly improve the quality of the review product and channels of communication. In late 1992, a pilot program offering an alternative dispute resolution was conducted with BCBSM.

An extension of the PROM medical record review was a study of HCFA Mortality Data requested by a Michigan hospital. PROM analyzed the HCFA data and conducted peer review of a sample of Medicare beneficiaries.

PROM staff participated with the MSMS Workers' Compensation Task Force to discuss promotion of an appellate process to the Workers' Compensation system. PROM continues interest in assisting the many carriers to develop uniform processing standards with PROM offering appellate services.

PROM continues to seek reviewers who are in active practice and board certified within their respective specialty.

PROM efforts to seek reviewers has incorporated contact with selected specialty societies, recommendations from MSMS and PROM Boards of Directors, articles in *Medigram*, county publications and personal contacts. Physicians are generally receptive to PROM requests to serve as review consultants recognizing both the *need* for the service and the educational *value* for the reviewer.

Credentialing and privileging issues are an extension of the peer review activities of PROM. Our review services may complement the ongoing peer review efforts of a medical staff. Supporting the efforts of the medical staff through an external independent objective review may be helpful in assessing the quality of care provided by specific members of the medical staff. PROM has assisted several hospitals in the review of medical staff applications for appropriateness of experience and training for privileging issues. Credentialing activity has brought PROM interaction with the Michigan Professional Credential Verification Service.

PROM is establishing its position as a consultant to health insurers, hospitals and other health organizations in the areas of peer review and credentialing. PROM building upon its current base of knowledge must maintain the flexiblity to respond to the changing challenges presented by healthcare organizations.

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# **Exaugural Address**



Outgoing MSMS President Thomas C. Payne, MD, discusses the many achievements made during his presidency and reminds members of the House that unity is the key to accomplishing goals.

year ago in my inaugural address I mentioned five key topics that I presented to you for your consideration: Participation, Representation, Involvement, Dedication, and Environment. What I'd like to do now is update you on how your medical society has tried to address these issues.

#### **Participation - Communication**

First of all let's talk about participation. I have three main areas I would like to address under participation:

1. Traditionally, each MSMS president travels around the state talking to county medical societies and I have carried on this tradition. I have talked to approximately 25 component societies. As an organization, MSMS is trying to reach all physicians in the state. We have implemented a program through our Hospital Medical Staff Section to talk at hospital medical staff meetings in addition to our regular visitation to county medical societies. In the past year I have had the opportunity to talk to 12 separate medical staffs covering areas ranging from Watervleit Community Hospital to West Shore Hospital in Manistee and to Caro Community Hospital in the Michigan thumb.

2. The second item concerns working with the legislature. We instituted a new program this year when we arranged for grassroots meetings with legislators in their

# A year of "pride"

"Remember, working together we can make a difference."

Thomas C. Payne, MD

districts across the state. We met with all 27 new legislators. This proved to be a valuable introduction to the new members of the House of Representatives. We also hosted our traditional reception with the new legislators at MSMS Headquarters. Twenty of the 27 attended. I mentioned that specifically because one of the new representatives sought me out before his vote on the crucial legislation on liability.

3. The third area of participation for me was communication. When I first took this job I realized that I would have to prioritize what areas I thought were most important. One area that I thought should be on this list was communications with the media. To address this I made myself available for interviews with any radio and television station and newspaper. I have done approximately 300 interviews in the past year to get medicine's voice heard. All in all MSMS has had 600 media communications this past year. This along with legislation has become the two main thrusts of my presidency.

#### Representation - Assisted Suicide

Since 60 percent of the general population think there is a role for physician-assisted suicide, MSMS thought that we should further study this issue. MSMS convened multidisciplinary forums in December of 1991 and has met on a monthly basis since that time. Their deliberations have resulted in a report to the MSMS Bioethics Committee which will serve as a starting point on our position. This report, along with  $10\,\mathrm{resolutions}$ , will serve as the focal point for our deliberation.

#### **Involvement - Health Care Reform**

The day that President Clinton was inaugurated he stated that he wanted to have a health care reform plan within 100 days. I quickly figured out that I would be president of

MSMS 101 days from his inauguration date which gave me one day to do something about it if he got it wrong. Since President Clinton has missed that deadline this challenge now falls on our incoming president, Gilbert Bluhm, MD. This will at least give him something to do.

We have already started to address this issue. MSMS Past President Susan H. Adelman, MD, and I were panelists on one of the town meeting



MD, (right) with his past president's pin.

health care reform panels put together with the Robert Wood Johnson Foundation in conjunction with Hillary Rodham Clinton. This did give us the opportunity to get across some of medicine's concern about health care reform. Another panel was convened by Congressman Sander Levin who serves as vice chairman of the US House of Representatives Ways and Means Committee. I also had the opportunity to participate in that hearing.

#### **Dedication - Professional Liability**

MSMS has been involved in this issue for 20 years and we finally see the culmination of our work on the passage of professional liability legislation. Our detractors say it won't cut down on professional liability premiums and won't stop defense medicine. We as a profession must work to prove them wrong.

#### **Environment - Domestic Violence**

This item refers to MSMS' program on domestic violence which served as a cornerstone of my presidency. I am happy to report that the program has gone well and will continue as a permanent task force of the medical society. We have already taken three steps on this journey, which is probably 50 steps long. A lot more needs to be done and I hope we can accomplish this in the not too distant future.

#### Fragmentation the biggest concern

You have heard about the four biggest issues I have faced in my presidency: physician-assisted suicide, health care reform, professional liability and domestic violence. I'd now like to talk to you about one of my biggest concerns. This concern is about fragmentation of the profession. We need to speak with a unified voice. Splinter groups detract from the issues at hand. It was never so clear as in the professional liability debate when opposing legislation almost upset meaningful liability reform. We must work together.

Finally, I want to commend our excellent staff members of the Michigan State Medical Society. Though I knew most of them before - after this year I really know them. You should be proud of all 82 people who work with us to address the concerns of the medical profession. As some of you have heard me say before. I spent the first eight years of my practice driving past the headquarters on my way to work wondering what they did in that building. I now know what they do. They serve us well. Although I would like to single out individuals for commendation I resist that, as it is a team effort. Without them I could not have done this job.

Take Participation, Representation, Involvement, Dedication, Environment, put them together and what do you have? You have PRIDE. I have even more pride in my profession than a year ago and I hope you do, too. Remember that working together we can make a difference.





Sixty Michigan physicians were presented an award for 50 years of service,

#### Fifty-Year Awards

Fifty-year awards were presented to the following physicians:

Frederick M. Adams, MD, Birmingham, MI James J. Aiuto, MD, Mt. Clemens, MI A. P. Albarran, MD, West Bloomfield, MI Millard J. Albers, MD, Saginaw, MI Charles W. Aldridge, MD, Grand Rapids, MI Francis C. Anderson, MD, Escanaba, MI Norma E. Anderson, MD. Snover, MI Robert S. Bailey, MD, Port Huron, MI Radivoj R. Barber, MD, Livonia, MI Manley L. Barry, MD, Kalamazoo, MI William H. Benner, MD, St. Joseph, MI Allen Berlin, MD, Southfield, MI Eldean G. Betz, MD, Kalamazoo, MI Marenus J. Beukema, MD. Lowell, MI John G. Bielawski, MD, Dearborn Heights, MI Thomas H. Billingslea, MD, Detroit, MI John R. Birmingham, MD, Farmington Hills, MI Alexander Blain, MD, Grosse Pointe, MI David C. Boyce, MD, Grand Rapids, MI Wilson K. Brewer, MD, Ann Arbor, MI William J. Briggs, MD, Grosse Pointe Farms, MI John W. Brown, MD, Lansing, MI Edgar S. Bruer, MD, Lewiston, MI Donald R. Bryant, MD, Harbor Springs, MI Rockwood W. Bullard, MD, Clarkston, MI Jerry E. Bulthuis, MD, Holland, MI Irving F. Burton, MD, Huntington Woods, MI J. Max Busard, MD, Muskegon, MI John R. Caldwell, MD, Birmingham, MI John S. Campbell, MD, Bay City, MI William D. Cheney, MD, Okemos, MI Clarence P. Chrest, MD, Valley, AZ William D. Cleland, MD, Port Huron, MI Parish B. Cleveland, MD, Grosse Ile, MI Robert G. Combs, MD, East Lansing, MI John F. Cotant, MD, Northville, MI Garmet C. Cutler, MD, Flushing, MI James C. Danforth, MD, Grosse Pointe Shores.

James C. Danforth, MD, Grosse Pointe Sho MI James D. Darnley, MD, Birmingham, MI Christie E. Davis, MD, Ludington, MI George C. DeSmyter, MD, East Detroit, MI Peter J. DeVries, MD, Spring Lake, MI Thomas E. Del Giorno, MD, Mecosta, MI

John D. DeMay, MD, Jackson, MI Herbert W. Devine, MD, Grosse Pointe, MI Edward R. Doezema, MD, Ann Arbor, MI Edward A. Dolan, MD, Bellevue, WA Malcolm K. Dolbee, MD, Standish, MI Raymond M. Engelman, MD, Flint, MI George S. Evseeff, MD, Southfield, MI William R. Eyler, MD, Detroit, MI William G. Fenner, MD, St. Clair, MI John D. Folsom, MD, North Muskegon, MI Arthur B. French, MD, Ann Arbor, MI Joseph J. Gadbaw, MD, West Bloomfield, MI Richard R. Galpin, MD, Royal Oak, MI Adam E. Gamon, MD, Brandt, MI Abraham H. Grant, MD, Southfield, MI Thomas L. Hackett, MD, Sedona, AZ Leonard J. Hallen, MD, Lathrup Village, MI Herbert E. Hamel, MD. St. Ignace, MI Walter W. Hassig, MD, Grosse Pointe Farms, MI Herbert J. Hazledine, MD, Oldsmar, FL John W. Henderson, MD, Ann Arbor, MI Benjamin E. Henig, MD, Hilton Head Island, SC Harold B. Herbst, MD, West Bloomfield, MI Donald V. Hobbs, MD, Brighton, MI Frederic L. Hoch, MD, Ann Arbor, MI Charles J. Holt, MD, Oldsmar, FL Glenn W. House, MD, Greenville, MI Michael Hranchook, MD, Bloomfield Hills, MI Frederick W. Hyde, MD, Lathrup Village, MI Martin J. Ittner, MD, Traverse City, MI William Jend, MD, Bloomfield Hills, MI William S. Jones, MD, Menominee, MI Alvin E. Judd, MD, Flint, MI LeRoy W. Juhnke, MD, Mt. Pleasant, MI Donald B. Jury, MD, Carlsbad, CA Joseph B. Kearney, MD, Holland, MI Malcolm J. Kelson, MD, Detroit, MI Albert H. Kempter, MD, Ada, MI William B. Kirtland, MD, Detroit, MI Sidney D. Kobernick, MD, Sarasota, FL John C. Kretzschmar, MD, Boca Raton, FL John D. Kutsche, MD, Trenton, MI Paul T. Lahti, MD, Tucson, AZ Richard I. Larned, MD, Marusville, MI Alvin R. Larson MD, Bloomfield Hills, MI Jack M. Leopard, MD, Alpena, MI Irving Levitt, MD, Bloomfield Hills, MI Harry E. Lichtwardt, MD, Orchard Lake, MI Lewis E. Maire, MD, Muskegon, MI

John W. Manning, MD. Saginaw, MI Alexander P. Markey, MD, Big Rapids, MI Robert G. Martin, MD, Charlevoix, MI Kenneth P. Mathews, MD, La Jolla, CA Theodore M. Mattson MD. Marquette, MI John W. McCrea, MD, Lakeland, FL John N. McNair, MD, Muskegon, MI Bernard Meeuwsen, MD, Holland, MI Walter A. Meier, MD, Monroe, MI Albert H. Meinke, MD, Kewadin, MI Marjorie P. Meyers, MD, Detroit, MI Sidney S. Meyers, MD, Grosse Pointe Shores, MI Sidney S. Miller, MD, Huntington Woods, MI Robert C. Monson, MD, Detroit, MI G. Arthur Mulder, MD, Grand Rapids, MI Reinard P. Nanzig, MD, Grand Rapids, MI Cornelius A. Navori, MD, Sarasota, FL Adrian J. Neerken, MD, Ann Arbor, MI Paul R. Noble, MD, Monument Beach, MA Orville W. Oughtred, MD, Ontario, CA Ignatius J. Palmisano, MD, Livonia, MI Walter A. Payne, MD, Grosse Pointe, MI George V. Pendy, MD. Grosse Pointe Farms, MI Carl A. Peterson, MD, Hillsdale, MI Carol K. Platz, MD, Grosse Pointe Woods, MI Janis Pone, MD, Kalamazoo, MI Albert E. Posthuma, MD, Grand Rapids, MI Robert F. Powers, MD, Manistee, MI John R. Pracher, MD, Jacksonville, FL Robert J. Priest, MD, Grosse Pointe, MI Sidney N. Prystowsky, MD, Bloomfield Hills, MI Francis L. Purcell, MD, Ann Arbor, MI James W. Rae, MD, Leland, MI Frank P. Raiford, MD, Detroit, MI Dean K. Ray, MD, St. Joseph, MI James A. Read, MD, Bloomfield Hills, MI Harold R. Reames, MD, Austin, TX John W. Rebuck, MD, Birmingham, MI Richard G. Ries, MD, Jackson, MI John L. Riker, MD, Ossineke, MI Robert W. Rinkel, MD, Allen Park, MI James H. Robinson, MD, Southfield, MI Herbert Rosenbaum, MD, Southfield, MI William Rottschaefer, MD, Holland, MI Russell C. Rowan, MD, Albion, MI William A. Sautter, MD, Horton, MI Werner F. Schmidt, MD, St. Clair Shores, MI Ernst O. Schreiber, MD, Harlington, TX Arthur E. Schultz, MD, Hilton Head, SC

Nathan P. Segel, MD, Farmington, MI Stanley J. Shanoski, MD, Sun City West, AZ Sheila Sheehan, MD, Detroit, MI Alfred J. Shreve, MD, Port St. Lucie, FL Herschel A. Shulman, MD, Southfield, MI John W. Sigler, MD, Birmingham, MI Donald R. Simmons, MD, Taylor, MI K. R. Slatmyer, MD, Mattawan, MI John Small, MD, Detroit, MI Homer M. Smathers, MD, West Bloomfield, MI John W. Smillie, MD, Ann Arbor, MI William S. Smith, MD, Brighton, MI Alfred J. Spagnuolo, MD. Lansing, MI James E. Spens, MD, Alpena, MI Edward E. Steinhardt, MD, Bad Axe, MI Lewis L. Stewart, MD, Jackson, MI Robert H. Stobbelaar, MD. St. Joseph, MI Robert M. Stow, MD. East Lansing, MI Joan C. Stryker, MD, Detroit, MI Keh-Ming Sun, MD, Grand Rapids, MI Raymond H. Suwinski, MD, Grosse Pointe Shores, MI

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Leonard F. Van Raaphorst, MD. Fort Muers, FL A. R. Vandenberg, MD, Grand Rapids, MI Keats K. Vining, MD, Grand Rapids, MI Albert A. Wallaert, MD, East Detroit, MI John F. Walters, MD, Battle Creek, MI Kathryn D. Weburg, MD, Petoskey, MI Jack E. Weih, MD, Traverse City, MI Arno W. Weiss, MD, Saginaw, MI Keith E. Weller, MD, Grand Rapids, MI Joseph L. Whelen, MD, Mancelona, MI Keith H. Whitehouse, MD, Morenci, MI Leo R. Wickert, MD, Mt. Pleasant, MI Andrew G. Wilson, MD, Rochester, MI Charles H. Wright, MD, Southfield, MI William C. Wyte, MD, Marco Island, FL S. A. Yannitelli, MD, Battle Creek, MI Henry J. Zukowski, MD, Detroit, MI

#### **National President Award**

This award was presented to the following physicians for their service as presidents of national medical organizations.

Robert H. Burke, MD, President American Association of Cranio-Maxillofacial Surgeons

Julian T. Hoff, MD, President

American Association of Neurological Surgeons

Richard L. La Mont, MD, President
Mid-American Orthopaedic Association
Conrad E. Nagle, MD, President
American College of Nuclear Physicians
Apando S. Brand, MD, President

Ananda S. Prasad, MD, President American College of Nutrition

Frank N. Ritter, MD, President American Laryngological, Rhinological and Otological Society

#### Frederick and Besse Moulton Plessner Memorial

This award is presented by the MSMS Board of Directors to a rural physician who "best exemplifies the practice and ethics of a rural country practitioner. This year's recipient was:

James F. Shetlar, MD, Frankenmuth, MI

#### Flag Award

This award was presented to the following president of a statewide non-medical organization:

Jagan R. Kakarala, MD, Troy, MI

# **House of Delegates Certificate of Appreciation**

This award, given to MSMS members for their past service on the Michigan Delegation to the American Medical Association, was presented to:

Robert D. Allaben, MD, Gaylord, MI Robert W. Black, MD, Detroit, MI Donald K. Crandall, MD, Muskegon, MI

#### **Presidential Citation**

This award, presented to physicians or lay persons who have made an outstanding contribution to medicine in the state, was presented to the following physician:

Roger F. Smith, MD, Detroit, MI

#### **Community Service Awards**

This award was presented to the following physicians who were nominated by their county medical societies for special contributions to their community and/or humanity: Jaime V. Aragones, MD, Oakland County Medical Society, Rochester

Hira A. Branch, MD, Genesee County Medical Society, Flint

William R. Engelman, MD, Saginaw County Medical Society, Saginaw

David G. Flagler, MD, Kalamazoo Academy of Medicine, Kalamazoo

Paul R. Gradolph, MD, Macomb County Medical Society, Birmingham

Ronald Isley, MD, Lenawee County Medical Society, Blissfield

Rhoda M. Powsner, MD, Washtenaw County Medical Society, Ann Arbor

Alfred B. Swanson, MD, Kent County Medical Society, Grand Rapids

Joseph W. Wiley, MD, Ingham County Medical Society, Lansing

#### **Certificate of Appreciation**

A special Certificate of Appreciation was presented to the following physician for a decade of distinguished service, on behalf of MSMS, on the Blue Cross Blue Shield Board and as a Corporate member:

Richard L. Rapport, MD, Flint, MI

#### **Elections**

The 1993 House of Delegates elected the following MSMS officers and directors, as well as delegates and alternates to the American Medical Association.

#### **OFFICERS**

(to the 1994 Annual Session)
President

Gilbert B. Bluhm, MD, *Troy* **President-Elect** 

Jack L. Barry, MD, Saginaw

Immediate Past President
Thomas C. Pavne, MD, East Lansing

**Board of Directors Chair** 

W. Peter McCabe, MD, Grosse Pointe Woods

#### **Board of Directors** Vice Chair

Peter A. Duhamel, MD, Rochester Hills Speaker of the House of Delegates Gary D. Maynard, MD, Kalamazoo

Vice Speaker of the House of Delegates

Dorothy Kahkonen, MD, Detroit

#### DISTRICT DIRECTORS (to the 1996 Annual Session) 1st District

Robert W. Black, MD, *Detroit* W. Peter McCabe, MD, *Grosse Pte. Woods* 

Krishna K. Sawhney, MD, Taylor

**7th District**David "Moore" Hislop, MD, *Port Huron* 

8th District
Richard C. Hausler, MD. Sagingu.

Richard C. Hausler, MD, Saginaw 12th District

Jaak M. Pahn, MD, Sault Ste. Marie 14th District

Fred E. Patterson, MD, *Jackson* **15th District** 

Peter A. Duhamel, MD, Rochester

# DELEGATES TO THE AMA (to the 1995 Annual Session)

Rhoda M. Powsner, MD, Ann Arbor

# ALTERNATE DELEGATES TO THE AMA

Domenic R. Federico, MD, *Grand Rapids* (term ending 1994) Krishna K. Sawhney, MD, *Taylor* 

(term ending 1995)
Lynn Bergquist (student), Lansing
(term ending 1994)



Michigan Medicine



# Special Memberships

#### LIFE MEMBERSHIPS

A life member is any physician who has maintained an active membership in good standing for 25 years in any one or more constituent state societies of the American Medical Association with any five years in Michigan. Those recognized at the 1993 MSMS House of Delegates include:

**Barry** Robert B. Pryor, MD; Jack L. Tromp, MD

Benzie Stanley L. Michael, MD
Calhoun Steven G. Tarangle, MD
Dickinson Warren J. Roberts, MD
Genesee Richard D. Hackley, MD;
Robert S. Ormond, MD; Philip G.
Seven, MD; Sarjit Singh, MD
Huron Manuel L. Teves, MD
Isabella Donald A. Dunlop, MD

Jackson Gerald I. Maas, MD; John M.

McLaughlin, MD

**Kalamazoo** Robert H. Hume, MD **Kent** Willis L. Dixon, MD; George H. Lewis, MD

Lenawee Jaroslav Oceretko, MD Macomb William G. Grannis, MD; Norman Zucker, MD

Muskegon William H. Bond, MD; Albert D. Engstrom, MD; Lambertus Mulder, MD; Sachiki K. Okamoto, MD Northern Michigan George W. Wright, MD

Oakland Joseph A. Arena, MD; Raymond A. Gagliardi, MD; Warren W. Goodwin, MD; Louis Hoffman, MD; Cyril D. Jones, MD; Henry D. Kaine, MD; Gharbharan R. Mathura, MD; Donald C. Overy, MD; Constantin Predeteanu, MD

**Saginaw** Frederick J. Cady, MD; Eleanor Kovich, MD; Byron B. Lutes, MD;

Sanilac Duane E. Smith, MD
Washtenaw Louis P. Kivi, MD
Wayne F. Ross Birkhill, MD; Eli M.
Brown, MD; Waldo L. Cain, MD; Henry
M. Domzalski, MD; Alexander P. Kelly,
MD; Kenneth L. Krabbenhoft, MD;
Donald J. Largo, MD; Ira Leventer, MD;
Morris J. Lipnik, MD; Rosser L.
Mainwaring, MD; Burton V. Matthews,
MD; William G. Mc Donald, MD; Samuel
Mendoza, MD; Frederick G. Porter, MD;
Russel F. Proud, MD; Heinz R.

Schroeder, MD; Abraham B. Solomon,

MD; Charles A. Steepe, MD; Robert H.

Sturman, MD; Natalia M. Tanner, MD;

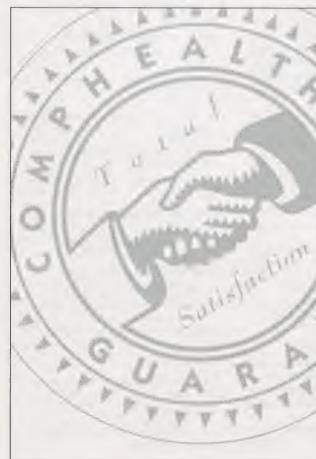
L. Murray Thomas, MD; Arthur A.

Ulmer, MD; L. H. Warbasse, Jr., MD

St. Clair Michael Raftery, MD

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who have maintained membership for five years in the component medical society and are retired from active practice. Those recognized at the 1992 MSMS House of Delegates include:

**Bay** - Nicholas Csonka, MD; Paul J. Hettle, MD

**Berrien** - Walter Kirsten, MD; Wadi Jibrail, MD

Branch - L. Don Pipe, MD

**Calhoun**-Gregory Burhans, MD; Felipe H. Regualos, MD

**Chippewa-Mackinac** - Quinter M. Burnett, MD

Delta - William A. LeMire, III, MD

Eaton - Eber Sherman, MD

Emmett - Ian D. Wilson, MD

Genesee - Jack E. Benkert, MD; C. Arch Brown, MD; Lawrence Irish, MD; O. Foster Kline, Jr., MD; Leslie L. LeMieux, MD; Richard M. Lundeen, MD; Berton J. Mathias, MD; S. Harry Nasser, MD; Jack E. Portney, MD; John Quin, Jr., MD Gratiot - Richard J. Remsberg, MD

Ingham - John W. Anderson, Jr., MD;

Thomas C. Blair, MD; Donald B. Mc Corbie, MD; John F. Plant, MD; Harry J. Schmidt, MD; Joseph L. Sheets, MD; J. Clyde Spencer, MD; Gerald A. Vander Voord, MD; Douglas F. Wacker, MD

**Kalamazoo** - Daniel Christian, MD; J. William Fry, MD; Richard E. Gibson, MD; Donald E. Herendeen, MD; Russell E. Mohney, MD

Kent - Ram Advani, MD; Manuel M. Campos, MD; Enrique E. Fierens, MD; Daniel W. Johnston, MD; Linh T. Le, MD; Warren B. Mason, MD; James D. O'Brien, MD; William G. O'Driscoll, MD; Harry E. Schneiter, MD; Jerome W. Swan, MD; Robert L. Troske, MD; John VanderMolen, MD; Robert J. Westerhoff, MD

Macomb - Morris Starkman, MD

Midland - Winifred A. Oyen, MD

North Central - Sambamurti Srinivasan, MD

Oakland - Charles Berman, MD; Edward E. Elder, MD; Gordon R. A. Fishman, MD; Seymour Gordon, MD; Salah J. Hammou, MD; Howard N.

Manz, MD; Candida C. Misra, MD; Gerald C. Timmis, MD; Thomas G. Varbedian, MD; Richard A. Wetzel, MD

Ottawa - Arnold R. Dood, MD

St. Clair - Elmore D. Shoudy, MD

St. Joseph - Robert Hill, MD

Saginaw - Gerald Scott, MD

Washtenaw - Jaroslav M. Bandera, MD; Rodney R. Bentz, MD; Walter G. Brovins, MD; Rodrigo Diaz-Perez, MD; Joseph S. Jacob, MD; Patricia A. O'Connor, MD; Thomas R. Peterson, MD

Wayne - Vincent B. Adams, MD; Julian B. Alvarez, MD; Gilbert M. Bazil, MD; Robert L. Brent, MD; Zofia J. F. Drozdowska, MD; Gerhard C. Endler, MD; Josef M. Kobiljak, MD; Ramon A. Madrid, MD; Robert C. Marvin, MD; Helen A. Papaioanou, MD; John Piligian, MD; Epimaco O. Rubio, MD; Gene A. Saunders, MD; Albert Tactac, MD; Raymond R. Wysocki, MD

**Wexford-Missaukee** - Nora F. Change, MD; George F. Wagoner, MD



# HEPATITIS B VACCINE DISCOUNT AVAILABLE TO MSMS MEMBERS

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### **Board Action Items**



Nine MSMS past presidents gathered for a photo the evening of the presidential ball. They are (l to r): Thomas R. Berglund, MD; Louis R. Zako, MD; Robert E. Paxton, MD; Susan H. Adelman, MD; Thomas C. Payne, MD; Carl A. Gagliardi, MD; John J. Coury, MD; Robert D. Burton, MD; and Richard J. McMurray, MD.

Action Report #1: 1992 Board Action Report #3 - Post Operative Care (Resolution 29-91A)

**RECOMMENDATION:** That the Resolved portion of Resolution 29-91A be changed to read, that MSMS support the position that post-operative care must be provided by the operating surgeon or by *a licensed physician trained in surgery, designated by the operating surgeon*, and that amended Resolution 29-91A be adopted.

House of Delegates Resolution 29-91A, referred to the MSMS Board of Directors for study, asked that MSMS support the position that post-operative care must be provided by the operating surgeon or an equivalently trained and licensed physician.

The Board of Directors, after receiving a recommendation from the Committee on Medical Licensure and Discipline, developed for the 1992 House of Delegates Board Action Report #3, which stated that in some cases, it may not be possible for the operating surgeon to provide post-operative care. The report provides that in those cases, the individual who replaces him or her should be supervised by the operating surgeon. The MSMS House of Delegates referred this report back to the Board of Directors for further study.

The Board agrees with the intent of the original House of Delegates resolution, however, is concerned that the concept of "an equivalently trained and licensed physician" may have liability implications for the operating physician. The Board therefore recommends the resolved portion be changed and that this resolution be adopted as amended.

Reference Committee E on Public Health and Miscellaneous recommended Board Action Report #1 be adopted as amended.

The House approved the recommendation of the Reference Committee.

Action Report #2: Policy Statement on Physician-Assisted Suicide

**RECOMMENDATION:** That the attached statement on physician-assisted suicide be endorsed by the 1993 House of Delegates.

The MSMS Board of Directors adopted the AMA statement on physician-assisted suicide in October 1991 as an interim policy. At the May 1992 House of Delegates meeting, MSMS reversed the Board's decision and it was resolved not to seek any legislation related to physician-assisted suicide. In addition, it was resolved that there should be further dialogue on assisted suicide and that the AMA statement on assisted suicide be referred back to the Board for further discussion (Board Action Report #15). The MSMS Board of Directors instructed the Committee on Bioethics to develop a position statement on assisted suicide.

The Committee on Bioethics continued its examination of the moral, ethical, medical and legal ramifications of assisted suicide, with input from the participants of the physician-assisted suicide forums. In February of this year, the Committee on Bioethics developed a document. The Committee realized that it was not possible to develop a single, consensual statement on assisted suicide. Thus, the document consists of nine points of consensus and a summary of the arguments for and against assisted suicide. All members of the Committee endorsed the document, yet they retained the right to list themselves under the portion of the document they personally support.

Beyond the discussion on physician-assisted suicide the Committee recognizes the need for renewed professional efforts on behalf of patients suffering with terminal or incurable long-term illness.

The MSMS Board of Directors supports this recommendation. Reference Committee C on Internal Affairs and Public Service recommended Board Action Report #2 be adopted as amended.

The House approved the recommendation of the Reference Committee.

Action Report #3: Resolution 52-92A - Taxation of Medical Insurance Premiums

**RECOMMENDATION:** No further action be taken on Resolution 52-92A since the AMA has already incorporated the concept

within the Resolution in its Second Edition of Health Access America

Resolution 52-92A seeks changes in the AMA Health Access America campaign related to tax treatment of expenses for employee benefits. Specifically, the resolution advocates changes in state and federal tax law that would allow small businesses to receive a tax credit for health insurance premium expenses. The resolution was referred to the Board for study and subsequently referred to the Advisory Committee on Medical Economics.

AMA's Health Access America plan calls for expanded access to health care through several reforms, including mandatory employer based coverage. Recognizing the financial burden health insurance coverage places on business, Health Access America supports the development of several incentives for employers providing health insurance coverage for employees.

In 1992, the AMA released the second edition of Health Access America, incorporating several refinements to the original proposal. The Advisory Committee has reviewed the second edition of Health Access America and notes the inclusion of several incentives for employers to provide health insurance. Specific recommendations related to the resolution include:

- A federal sliding scale tax credit for small businesses whose insurance premiums for a minimum benefit package exceed a designated percentage of payroll and a designated percentage of before tax income.
- The extension of additional tax benefits to all new businesses, permitting a 150 percent tax deduction for health insurance premium costs during the first year of operation and a 125 percent tax deduction for the same costs during the second year of operation.
- The development of a federal incentive program for the creation of private health insurance pools for small businesses.

The Advisory Committee will continue to monitor refinements to Health Access America and proposals for health reform to determine if incentives for small businesses are consistent with the resolution. Since the AMA has already incorporated the concept within the resolution in its Second Edition of Health Access America, the Advisory Committee recommends no further action on Resolution 52-92A.

The MSMS Board of Directors supports this recommendation. Reference Committee A on Medical Care Delivery recommended Board Action Report #3 be approved.

The House approved the recommendation of the Reference Committee.

Action Report #4: Resolution 65-92A - Inappropriate Curtailment of Mental Health Services

**RECOMMENDATION:** That this report be adopted in lieu of Resolution 65-92A.

Resolution 65-92A, which was referred to the MSMS Board of Directors, asks that MSMS seek a moratorium on the closing of Coldwater Regional Psychiatric Hospital, the Lafayette Clinic, and other centers of excellence. The resolution also asks that MSMS seek mandated close cooperation between community mental health centers and private and public hospitals. In addition, the resolution asks that MSMS request Governor Engler to appoint an ad hoc task force to design a plan for integrating inpatient and outpatient services in a cost effective manner.

At the request of the MSMS Board of Directors, MSMS has

hosted six meetings between representatives of the Michigan Psychiatric Society (MPS), officials of the Michigan Department of Public Health (MDPH), and staff of the Governor's Office. Many issues have been discussed at these meetings, including psychiatric recruitment and retention, closure of state mental institutions, and community mental health issues. While MPS representatives and officials of the MDPH continue to disagree on some issues, including closure of state mental institutions, both parties agree that the meetings have resulted in each side having a better understanding of the other's position. The meetings also have resulted in finding areas of mutual concern, including the need to recruit psychiatrists to the public sector. All of the individuals involved have expressed strong support for the role MSMS has played in facilitating the meetings. The meetings will continue for the foreseeable future.

The MSMS Board of Directors supports this recommendation.

Reference Committee C on Internal Affairs and Public
Service recommended Board Action Report #4 be approved.

The House approved the recommendation of the Reference Committee.

Action Report #5: Resolution 66-92A - Health Care Financing Administration (HCFA) Proposal to Centralize All Peer Review Screening, Data Collection, and Abstraction Activities into Five Regional Central Data Abstraction Centers

**RECOMMENDATION ONE:** That MSMS neither oppose nor endorse Clinical Data Abstraction Centers (CDACs) until such time as the Uniform Clinical Data Set (UCDS) System has been evaluated for its accuracy, efficiency, and cost effectiveness by the AMA.

**RECOMMENDATION TWO:** That MSMS continue to support the local aspect of in-state review and that it monitor and compare regional review programs as they are being developed so that a more informed position can be developed.

The Resolved portions of Resolution 66-92A read:

RESOLVED: That MSMS oppose the establishment of CDACs; and be it further

RESOLVED: That MSMS urge HCFA to maintain and preserve the performance of all peer review activities within each state to designated statewide peer review organizations as currently done and as required by law.

The 1992 MSMS House of Delegates referred Resolution 66-92A, to the Board of Directors for study. The Board then referred this Resolution to the MSMS Liaison Committee with MPRO for study.

The Health Care Financing Administration (HCFA) had proposed to alter the method of data collection beginning July 1992, when the Uniform Clinical Data Set (UCDS) system was due for national implementation. Medical record data abstraction was to be performed by non-professionals in regionally based Clinical Data Abstraction Centers (CDACs).

The Committee learned that the American Medical Association had undertaken a cursory review of both HCFA's draft statement of work for the CDACs, and the American Peer Review Association's (AMPRA) white paper on this subject. In general, HCFA's proposed move to establish regionalized CDACs has some merit in that it may potentially improve the uniformity and consistency in which data are abstracted from the medical record,

Continued on following page

#### YOCON® YOHIMBINE HCI

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon\* is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug. <sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally. <sup>1,3</sup>

**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.  $^{1,3,4}$  1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to  $^{1/2}$  tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.  $^3$ 

How Supplied: Oral tablets of Yocon\* 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

- A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
- Goodman, Gilman The Pharmacological basis of Therapeutics 6th ed., p. 176-188.
   McMillan December Rev. 1/85.
- 3. Weekly Urological Clinical letter, 27:2, July 4,
- A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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64 North Summit Street Tenafly, New Jersey 07670 (201) 569-8502 1-800-237-9083 thereby improving the overall accuracy of the Uniform Clinical Data Set (UCDS).

In addition, a regionalized approach to data abstraction may allow for measured reliability in comparing physician and hospital profiles among all states. Moreover, this effort is consistent with the AMA's Medical Review Initiative which supports HCFA initiatives to develop alternative approaches to review activities that reduce the total level of hospital record review conducted by the Peer Review Organizations (PROs).

The Committee was informed that notwithstanding the potential benefits of CDACs, the AMA did have some concerns about the proposed implementation of such a vast and untested system of data abstraction. Because the data abstraction experience of the six states that have pilot tested UCDS has not been shared by HCFA, the AMA had no basis to determine whether it is prudent for HCFA to mandate the establishment of CDACs on a programwide basis at this time. By maintaining the flexibility to abstract data on both a local and regional basis, the AMA advised the Committee that HCFA will be better able to evaluate the accuracy, efficiency, and cost-effectiveness of clinical data abstraction.

In late spring, 1992, HCFA altered the plan for national implementation of a generic UCDS program to a focused program. Subsequent to this change, because the number of cases that will be subjected to UCDS were dramatically reduced, HCFA determined to contract with only one or two CDACs. One use of the CDAC system has been installed for the Cooperative Cardiovascular Project wherein four hospitals submit records for CDAC review. It is important to note that HCFA intends to implement the UCDS system for all medical record review and the implementation of CDACs near the end of the second year (1994) of the Fourth Scope of Work.

The MSMS Board of Directors, recognizing the potential improvements pertaining to uniformity and consistency in the abstraction of data from medical records that could occur by the implementation of a Uniform Clinical Data Set System and Clinical Data Abstraction Centers, determined to support the continued monitoring of the current review process and the development of the regional review process.

Reference Committee D on Professional Liability recommended Board Action Report #5 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #6: Resolution 90-92A - AMA Approved Fellowships

**RECOMMENDATION:** No further action be taken on Resolution 90-92A, since current AMA policy states that graduation from either an LCME approved medical school or an AOA approved medical school qualifies a graduate for an LCME-approved residency.

Resolution 90-92A asked "That the Michigan Delegation to the AMA request the AMA to seek changes so that osteopathic residents from AOA approved programs be allowed to qualify for all Liaison Committee on Medical Education fellowship programs." The 1992 House of Delegates referred this resolution to the Board for study.

MSMS staff checked with the AMA on the current status of requirements for entry to LCME residencies and fellowships. Current AMA policy states that graduation from either an LCME approved medical school or an AOA approved medical school qualifies a graduate for a LCME-approved residency, and there appears to be no further action needed.

The MSMS Board of Directors supports this recommendation. Reference Committee F on Medical Education and Miscellaneous recommended Board Action Report #6 be approved.

The House approved the recommendation of the Reference Committee.

#### Action Report #7: MSMS Policy Manual

**RECOMMENDATION:** That the House of Delegates reaffirm the policies contained in the Official Positions and Policies of the Michigan State Medical Society manual.

The House of Delegates last approved the entire Policy Manual in 1987. In 1982, the House took action requiring that every policy contained in the Manual be reaffirmed by the House at least once every five years to make sure that all policies represent the current position of the Society.

The Committee to Revise the Policy Manual chaired by Henry M. Domzalski, MD, and comprised of Robert D. Allaben, MD; James L. Fenton, MD; and Thomas E. Stone, MD, reviewed the Policy Manual and have included policies adopted by the MSMS Board of Directors through April 1992 as well as all policies adopted by the House since 1987.

The entire document is presented for House consideration. It is the recommendation of the Board that the document be reaffirmed in toto. However, if individual policies are to be removed or reworded, those particular policies should be returned without change to the Board and thence to the Policy Manual Committee to make the necessary changes in the Manual's text.

Reference Committee on Constitution and Bylaws recommended Board Action Report #7 be adopted.

The House approved the recommendation of the Reference Committee.

#### Action Report #8: Conflict of Interest Policy

**RECOMMENDATION:** That the House of Delegates adopt the following statement as the "Michigan State Medical Society Conflict of Interest Policy."

"All members of the Michigan State Medical Society Board of Directors should act in the best interests of MSMS. Any conflict of interest should be avoided.

"MSMS considers a potential conflict of interest to exist when a Director has a relationship with, or engages in any activity, or has any personal financial interest which might impair his or her independence or judgment or inappropriately influence his or her decisions or actions concerning MSMS matters. It is expected that conflicts of interest will be disclosed to the Board. The Board in its discretion will determine what, if any, limitations on activities with regard to the Director's conflict are required to protect MSMS.

"The Board shall report any matter it has found to be a conflict Continued on following page

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Continued from page 41

of interest to the House of Delegates annually."

In response to a 1992 House of Delegates resolution, the MSMS Board of Directors established the Conflict of Interest Committee.

The Conflict of Interest Committee met on March 31, 1993, and determined that a policy statement was necessary to guide the Committee in its activities. The recommended policy statement was adapted from the American Medical Association's conflict of interest policy. However, the proposed MSMS policy is stronger than the AMA's through the removal of the qualifying term "material conflicts" and addition of the first paragraph.

The MSMS Board of Directors supports this recommendation. Reference Committee C on Internal Affairs and Public Service recommended that Board Action Report #8 be adopted. (Board Report #8 was adopted in lieu of Resolution 122-93A)

The House approved the recommendation of the Reference Committee.

Action Report #9: Recognition of Specialty Society
RECOMMENDATION: That the 1993 MSMS House of Delegates approve upon First Reading MSMS Bylaws' amendments to recognize the Michigan Sleep Disorders Association for specialty society representation in the MSMS House of Delegates.

MSMS received a request from Paul Gouin, MD, President of the Michigan Sleep Disorders Association (MSDA), asking that the MSDA be recognized by the MSMS House of Delegates as a specialty organization.

It was determined that MSDA meets the requirements as delineated in Section 20.20 of the MSMS Bylaws:

"Other specialty organizations that wish to be included in the list of recognized specialty organizations in this chapter must meet the following criteria: a) Be a statewide specialty organization at least five years old; b) have 25 or more active physician members of whom 70 percent or more maintain their membership in MSMS; and c) be approved by the House of Delegates action, with the appropriate Bylaws amendments.

"A society must be statewide in scope, with a minimum of one meeting per year. In addition the governing body of the society must have taken formal action requesting delegate representation; i.e., sending a letter to the MSMS Board of Directors."

The MSMS Board of Directors supports this recommendation. Reference Committee on Constitution and Bylaws recommended Board Action Report #9 be adopted on first reading.

The House approved the recommendation of the Reference Committee.





#### Delegates' Record of Attendance

| April 30 - May 2 Meeting  |      | 0.     | 0 1    | GOGEBIC  |         |     |     | Domenic R. Federico, MD    | X     | X    | X    |
|---------------------------|------|--------|--------|--|---------|-----|-----|----------------------------|-------|------|------|
|                           | 1st  | 2nd    | 3rd    | Not Represented  |         |     |     | James R. Irwin, MD         | X     | X    | X    |
| OFFICERS                  |      |        |        | GRAND TRAVERSE-  |         |     |     | John H. Kopchick, MD       | -     | -    | -    |
| Speaker:                  |      | **     | **     | LEELANAU-BENZIE  | 37      | 37  | 3.7 | John M. MacKeigan, MD      | X     | X    | X    |
| Robert D. Allaben, MD     | X    | X      | X      | ,  | X       | X   | X   | Rolland D. Mambourg, MD    | -     | X    | X    |
| Vice Speaker:             |      |        | **     | David B. Martin, MD  | -       | X   | X   | Ann M. Minnema, MD         | X     | X    | X    |
| Gary D. Maynard, MD       | X    | X      | X      | Kenneth H. Musson, MD  | 37      | X   | X   | John P. Papp, MD           | -     | -    | -    |
| Secretary:                |      |        |        | Edward J. Rutkowski, MD  | X       | -   | X   | Brian V. Phillips, MD      | -     | -    | -    |
| Thomas R. Berglund, MD    | X    | X      | X      | GRATIOT  |         |     |     | Sarla Puri, MD             | X     | -    | X    |
| Delegates and Alternates  |      |        |        | Ashok R. Sonnad, MD  | -       | -   | -   | Jack L. Romence, MD        | X     | X    | X    |
| ALLEGAN                   |      |        |        | HILLSDALE  |         |     |     | Anthony Senagore, MD       | -     | -    | -    |
| Van O. Keeler, MD         | X    | X      | X      | Andrea D. Gelzer, MD   | -       | X   | X   | Peter D. Van Vliet, MD     | X     | X    | X    |
| ALPENA-ALCONA-PRESQU      |      | SLE    |        | , and the second | X       | -   | -   | James K. Watkins, MD       |       | X    | X    |
| Peter Aliferis, MD        | X    | X      | X      | HOUGHTON-BARAGA-KEW  | EE      | NAW |     | Susan B. Burke, MD         | X     | X    | -    |
| BARRY                     |      |        |        | Kenneth E. Rowe, MD  | X       | X   | X   | Gregory J. Forzley, MD     | -     | X    | X    |
| David M. Woodliff, MD     | X    | X      | X      | HURON  |         |     |     | Gwendolyn L. Hoffman, MD   | X     | X    | X    |
| BAY                       |      |        |        | Edward E. Steinhardt, MD   | X       | X   | X   | Robert C. Richard, MD      | X     | X    | X    |
| Shyam S. Dandamudi, MD    | -    | -      | -      | INGHAM   |         |     |     | David L. Sharp, MD         | X     | X    | -    |
| Robert C. Prophater, MD   | X    | X      | X      | Rolland E. Bethards, MD  | X       | X   | X   | Francis J. Verde, MD       | X     | X    | X    |
| Paul L. Chan, MD          | -    | X      | X      | Clyde R. Flory, MD   | X       | X   | X   | Kathleen J. Yost, MD       | X     | X    | X    |
| BERRIEN                   |      |        |        |  | X       |     | X   | LAPEER                     |       |      |      |
| Frank H. Bunker, MD       | X    | X      | X      | Robert A. Holmes, MD   | X       | X   | X   | William G. Tucker, MD      | X     | X    | -    |
| Fred M. Busse, MD         | X    | X      | X      | Omero S. Iung, MD  | X       | X   | X   | LENAWEE                    |       |      |      |
| Linda K. Stanley, MD      | X    | X      | X      | David K. Johnson, MD   |         | -   | -   | Inad Haddad, MD            | X     | X    | X    |
| Edward J. Westerbeke, MD  | - 28 | - 4%   | -      | Marsha Milburn, MD   | X       |     | X   | Nancy S. Newlin, MD        | _     | _    | -    |
| BRANCH                    |      |        |        | Mitchell A. Rinek, MD  | X       | X   | X   | LIVINGSTON                 |       |      |      |
| Jeffrey C. Custer, MD     |      |        |        | Dean G. Sienko, MD   |         | X   | X   | Edwin S. Woodworth, MD     | X     | -    | X    |
| CALHOUN                   | -    | •      | -      | Dawn E. Springer, MD   | X       | X   | X   | LUCE                       | 11    |      | 11   |
|                           |      | v      | v      | Ved V. Gossain, MD   | X       | -   | -   | Not Represented            |       |      |      |
| B. Douglas Campbell, MD   | -    | X      | X      | IONIA-MONTCALM   | 21      |     |     | MACOMB                     |       |      |      |
| Robert W. Oakes, MD       | v    | -      | X      | Louis E. Sanford, MD   | X       | X   | X   | James B. Anderson, MD      |       |      | X    |
| Margaret S. Skiles, MD    | X    | -<br>V | X<br>X | IOSCO-ARENAC   | Λ       | Λ   | Λ   | Arsenio V. DeLeon, Jr., MD | v     | X    | X    |
| Paul A. Walk, MD          | X    | X      | Λ      | Devendra K. Sharma, MD   | X       | X   | X   | Ben R. Fajardo, MD         | Λ     | Λ    | -    |
| CASS                      |      |        |        |  | Λ       | Λ   | Λ   | Paul R. Gradolph, MD       | -     | -    | -    |
| Boonchoo Chang, MD        | -    | -      | -      | ISABELLA-CLARE   | v       | v   | v   | Joel M. Kriegel, MD        | -     | X    | X    |
| CHIPPEWA-MACKINAW         | 37   | 3.7    |        | Thomas M. Keating, MD  | X       | X   | X   | Byung S. Lee, MD           |       | X    | X    |
| Jaak M. Pahn, MD          | X    | X      |        | JACKSON<br>In all D. C: A. M.D.  |         |     |     | Samir M. Ragheb, MD        | X     | X    | X    |
| CLINTON                   |      |        |        | Jack D. Gift, MD   | -<br>37 | -   | 3.7 |                            |       | Λ    | X    |
| Donald L. Porter, MD      | -    | •      | •      | Mary A. Mangelsen, MD  | X       | 3.7 | X   | Kenneth A. Weinberger, MD  | X     | X    | X    |
| DELTA                     |      |        |        | Moses Muzquiz, MD  | X       | X   | -   | Milton F. Simmons, MD      | Λ     | Λ    | Λ    |
| Carol A. Krieg, MD        | X    | X      | X      | Nicholas G. Bennett, MD  | -       | -   | X   | MANISTEE                   |       |      |      |
| DICKINSON-IRON            |      |        |        | KALAMAZOO  | 4.5     | **  | **  | Vickers C. Hansen, MD      | -     | -    | -    |
| Not Represented           |      |        |        | Owen M. Berow, MD  |         | X   | X   | MARQUETTE-ALGER            |       |      |      |
| EATON                     |      |        |        | M. Joseph Bowler, MD   |         | X   | X   | William G. Addison, MD     | -     | -    | -    |
| Sherman W. Horn, II, MD   | X    | -      | X      | Thomas M. George, MD   | X       | -   | X   | Randall M. Johnson, MD     | -     | -    | -    |
| GENESEE                   |      |        |        | Joseph E. Kincaid, MD  | -       | X   | X   | Satish J. Shah, MD         | -     | -    | -    |
| Ali A. Esfahani, MD       | -    | X      | -      | William J. Kube, MD  | X       | X   | X   | MASON                      |       |      |      |
| Cyrus Farrehi, MD         | -    | -      | -      | Gary D. Maynard, MD  | X       | X   | X   | Richard S. York, MD        | X     | X    | -    |
| George H. Greidinger, MD  | X    | X      | X      | Donna L. Ritter, MD  | X       | X   | X   | MECOSTA-OSCEOLA-LAKE       | C     |      |      |
| Vivian M. Lewis, MD       | X    | X      | X      | Ronald L. Vander Lugt, MD  | X       | X   | X   | Kathryn L. Mekaru, MD      | -     | -    | -    |
| AppaRao Mukkamala, MD     | X    | X      | X      | Geoffrey A. Wardwell, MD   | -       | X   | X   | MENOMINEE                  |       |      |      |
| W. Archibald Piper, MD    | -    |        | -      | Janice L. Werbinski, MD  | X       | X   | X   | Not Represented            |       |      |      |
| Frederick W. Sherrin, MD  | X    | X      | -      | William H. Woodhams, MD  | X       | X   | X   | MIDLAND                    |       |      |      |
| Allen F. Turcke, MD       | X    | X      | X      | KENT   |         |     |     | Roy M. Goethe, MD          | -     | -    | -    |
| Siavosh Varjavandi, MD    | -    | X      | -      | John H. Beernink, MD   | X       | X   | X   | Gary S. Smith, MD          |       | -    | -    |
| Virgilio G. Villareal, MD | X    | X      |        | R. Paul Clodfelder, MD   | X       | -   | X   | Robert L. Snyder, DO       | X     | X    | X    |
| Sudarsan Misra, MD        |      | -      |        | Douglas A. Edema, MD   | X       | X   | -   | MONROE                     |       |      |      |
| Jagdish K. Shah, MD       |      | X      |        | Paul O. Farr, MD   | X       | X   | X   | David J. Lieberman, MD     | X     | X    | X    |
|                           |      |        |        |  |         |     |     | Continued on               | follo | mina | nage |

| Continued from page 43             |     |        |        | Leroy C. Barry, MD        | X   | X  | X  | Juan A. Estigarribia, MD     | -      | -   | -    |
|------------------------------------|-----|--------|--------|---------------------------|-----|----|----|------------------------------|--------|-----|------|
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|-----------------------------|-----|
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| Physician Service Group     | 1   |
| PICOM                       | IFC |
| Premier                     | 46  |
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| Riverview Clinic            | 48  |
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| St. Luke's Hospital         | 22  |
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# PRESIDENT'S PAGE

# Managed Care: Just what is it anyway?

By Gilbert B. Bluhm, MD

s managed care (MC) a fact, fantasy or falsehood? Is it a new concept? Has it acquired a new meaning? As the concept of MC hangs in the wind of change, it is twisted and buffeted by the clamor for health system reform.

Physicians are trained and licensed in Michigan to diagnose and treat disease. Often some of the therapy is delegated and/or relegated by the physician to an allied health professional. Nevertheless, a physi-

cian-patient professional encounter rightly assumes the physician is expected to manage the care of the health problem. Therefore, will the original concept of managing care by the physician still prevail, or shall a deviant twist evolve for MC?

So far there appears to be two types of MC. At a recent meeting I attended in Chicago, it was pointed out one type has become more generic in recent years as the HMO, PPO, PPA, IPA, etc. The other type of MC is solely for managing cost. At the same AMA meeting, data quoted from the Health Insurance Association of America revealed 95 percent of employers offer one or more MC health plans. At a midsummer MSMS Board of Directors retreat four years ago, a presentation was made by an executive of a large insurance carrier on MC. Information was related that a large auto corporation intended to have all its employees nationwide covered by MC plans within five years.

Physicians remain crucial for any medical care organization. But as formulations of MC, CMSN (community medical service network), CCN (community care network), PO (physician organization) and PHO (physician-hospital organization) evolve it will be a prime responsibility of physicians to focus on managing care rather than just managing cost! Not to infer that physicians should ignore the cost of health care, but it is our duty to advocate the patient's well-being which must always remain at the center of our concern. Similarly, competition between us must not divide us, but motivate us to provide more efficient and effective patient medical management.

A recent definition of MC published by the American



Academy of Family Physicians caught my attention. To quote it: "A means of providing health care services within a defined network of health care providers who are given the responsibility to manage and provide quality, cost-effective health care." This definition accommodates the blend of both types of MC.

The Chair of the AMA Council on Medical Service cautioned last May that as physicians consider MC, six areas need to

be addressed: the product (benefits offered to the patient); the price (how are the costs and risks spread for patient and physician); the sale (by states, regions, communities, rural, urban, ERISA exempt); the modis operandi (by managed care organizations such as HMO, PPO, PPA, PO, PHO, or as a selective contract, capitation, RBRVS, Federal or State group; the accountability (for cost, quality, outcomes, patient satisfaction); and the impact (on innovation, creativity, medical education, rationed care). No doubt it will require more than glib slogans or advertisements for MC to succeed.

Patients still desire to choose their physician. Databases on physician quality and outcome must be improved, well designed, fair and accurate. The MC medical service network and benefits package must cover community patient needs. The physician will require the right to negotiate on administrative and medical-related patient issues and the cost of the benefit package. Will additional benefits be allowed or an interchange of coverage of equal cost be permitted?

In conclusion, MSMS is already poised and organized to assist its physicians to modulate the MC trend, a road littered with "mine fields" waiting to destroy the physician-patient relationship as we know it. We must not ignore the impending change in health delivery systems. Contact John Richards, MSMS division on Management and Organization Services with your questions, 517/336-7584, attend one of the numerous seminars scheduled around the state about POs/PHOs, and be proactive in your community with MSMS assistance.

Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. Clin Cardiol. 1991;14:146-151.

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Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosocierosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-COA reductase-inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-COA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that angrexia, weakness, and/or abdominal pain may also be present in

rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. As with other lipid-lowering agents, liver function tests should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or vary alcohol ingestion (see CLIMCAL PHARMACOLOGY: Pharmacokinetics/Metabolism) patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been re-

patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyoysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.195, Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomynolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepson.

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, epiforozil, enythormycin; or niscin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemifibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receivi

continued. The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS)

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential cliagnosis of chest pain in a patient on therapy with pravastatin. Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial Hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors. Renal insufficiency: A single 20 mg oral obse of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3a-hydroxy isomeric metabolite ISQ 31,906). A small increase was seen in mean AUC values and II-life (102) or the inactive enzymatic ring hydroxylation metabolite ISQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitiored.

Information for Patients: Patients should be malaise or fever.

weakness, particularly if accompanied by malaise or fever.

Drug Interactions: Immunosuppressive Drugs, Gernfibrozil, Niacin (Nicotinic Acid), Erythromycin: See WARN-INGS: Skeletal Muscle.

INVaS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system willi occur.

Cholestyramine/Colestinol: Concomitant administration resulted in an approximately 40 to 50% decrease in the

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean ALC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after choles-tyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bio-availability or therapeutic effect. (See DOSAGE AND ADMINISTRATION; Concomitant Therapy). Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravatin did not after the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but

bloadvailability parameters at steady state for javastatility pareir Configuration (Vereir to italience). Pravastatility of water for altered. Pravastatility of water for altered. Pravastatility of water for large for days of concomitant therapy). However, bleeding and extreme prolongation of prothorombin time asteed days of concomitant therapy). However, bleeding and extreme prolongation of prothorombin time has been reported with another drug in this class. Patients receiving warfarin-type anticagulants should have their prothorombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed. Cimetidine: The AUC<sub>0-12hr</sub> for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid. Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability parameters of digoxin were not affected. The AUC of pravastatin ended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered. Gerifibrozii: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gerifibrozii is generally not recommended. In interaction studies with aspirin, antacids 11 hour prior to PRAWACHOL (pravastatin new hen PRAWACHOL was administered.

was administered.

The Drugs: During clinical trials, no noticeable drug interactions were reported when PRAWACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers,

or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically biunt adrenal or gonadal steroid hormone production. Results of clinical Irails with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced (p<0.004) after 16 weeks of treatment with 40 mg pravastatin. However, the percentage of patients showing a ±50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dystunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell

infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class. A chemically similar drug in this class produced optic nerve degeneration (Mallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochilear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose. Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10,30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose (p<0.01). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

10. 30, of 100 mg/kg body weight, there was an increased incidence of hepafocellular carcinomas in males at the highest dose (< 0.01). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC. The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in he incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls (< 0.05). The incidence was not dose-related and male mice were not affected.
A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose emales and mid—and high-dose males. The incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in high-dose females. Drug treatment also significantly increased in end- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls. No evidence of mutagenicity was observed in vitro, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of Salmonella typhimurium or Escherichia coli; a forward mutation assay in L5178YTK +/ — mouse lymphoma cells; a chromosomal aberration test in hamster cells; and gene conversion assay using Saccharoryces corevisies. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in r Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular altrophy, de-creased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Pregnancy: Pregnancy Category X: See CONTHAINDICATIONS.
Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter²). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAMCHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAMACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: General.) ADVERSE REACTIONS

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients. Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below, also shown are the exceptances of natients in whom these medical events were helieved to be required to the drug.

percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

|                     | All Ever                 | nts %                | Events Attributed to Study Drug % |                      |  |
|---------------------|--------------------------|----------------------|-----------------------------------|----------------------|--|
| Body System/Event   | Pravastatin<br>(N = 900) | Placebo<br>(N = 411) | Pravastatin<br>(N = 900)          | Placebo<br>(N = 411) |  |
| Cardiovascular      |                          |                      |                                   |                      |  |
| Cardiac Chest Pain  | 4.0                      | 3.4                  | 0.1                               | 0.0                  |  |
| Dermatologic        |                          |                      |                                   |                      |  |
| Rash                | 4.0°                     | 1.1                  | 1.3                               | 0.9                  |  |
| Gastrointestinal    |                          |                      |                                   |                      |  |
| Nausea/Vomiting     | 7.3                      | 7.1                  | 2.9                               | 3.4                  |  |
| Diarrhea            | 6.2                      | 5.6                  | 2.0                               | 1.9                  |  |
| Abdominal Pain      | 5.4                      | 6.9                  | 2.0                               | 3.9                  |  |
| Constipation        | 4.0                      | 7.1                  | 2.4                               | 5.1                  |  |
| Flatulence          | 3.3                      | 3.6                  | 2.7                               | 3.4                  |  |
| Heartburn           | 2.9                      | 1.9                  | 2.0                               | 0.7                  |  |
| General             |                          |                      |                                   |                      |  |
| Fatigue             | 3.8                      | 3.4                  | 1.9                               | 1.0                  |  |
| Chest Pain          | 3.7                      | 1.9                  | 0.3                               | 0.2                  |  |
| Influenza           | 2.4*                     | 0.7                  | 0.0                               | 0.0                  |  |
| Musculoskeletal     |                          |                      |                                   |                      |  |
| Localized Pain      | 10.0                     | 9.0                  | 1.4                               | 1.5                  |  |
| Myalgia             | 2.7                      | 1.0                  | 0.6                               | 0.0                  |  |
| Nervous System      |                          |                      |                                   |                      |  |
| Headache            | 6.2                      | 3.9                  | 1.7°                              | 0.2                  |  |
| Dizziness           | 3.3                      | 3.2                  | 1.0                               | 0.5                  |  |
| Renal/Genitourinary |                          |                      |                                   |                      |  |
| Urinary Abnormality | 2.4                      | 2.9                  | 0.7                               | 1.2                  |  |
| Respiratory         |                          |                      |                                   |                      |  |
| Common Cold         | 7.0                      | 6.3                  | 0.0                               | 0.0                  |  |
| Rhinitis            | 4.0                      | 4.1                  | 0.1                               | 0.0                  |  |
| Cough               | 2.6                      | 1.7                  | 0.1                               | 0.0                  |  |

\*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral nerve palsy. 
Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyaigh rehumatica, vascultils, purpura, thrombocytopenia, leukopenia, hemophic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointesinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fullminant hepatic necrosis, and hepatoma, anorexia, vomiting. 
Reproductive: gynecomastia, loss of thiodio, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNIMGS).

observed (see WARNINGS).

observed (see WARNINGS).

Transient, asymptomatic exsinophilia has been reported. Ecsinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nice trice acid, probucol and germiforozil. Preliminary data suggest that the addition of either probucol or germiforozil to therapy with lovastatin or pravastatin is not associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without active tenal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemifibrozil, epythornycin, or ligid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: Skeletal Muscle and PRE/CAUTIONS: Drug Interactions.) Skeletal Muscle and PRECAUTIONS: Drug Interactions.)

Issued: March 1993

here have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.



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Active liver disease or unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of pravastatin sodium

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of proscribing information on the adjacent page.



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# MEDICINE

SEPTEMBER 1993 VOL. 92, NO. 9

Award-Winning Journal of the Michigan State Medical Society



Cover

#### A Special Update on POs & PHOs

MSMS: Preparing Michigan Physicians for Change

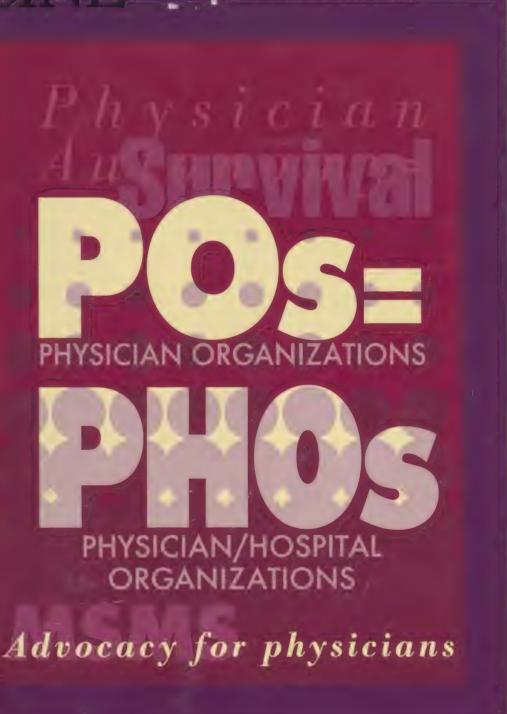
#### Also included:

MSMS Annual Scientific Meeting Preview

MSMS AIDS Provider Education Project Update

#### Plus:

- MSMS on the Move
- Reimbursement Roundup
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- Risk Management Exchange
- Medicine People





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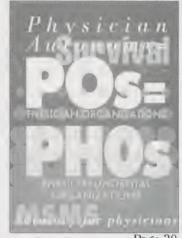
#### MICHIGAN MEDICINE

SEPTEMBER 1993 VOLUME 92, NO. 9

Award-Winning Journal of the Michigan State Medical Society

#### **COVER STORY**

This month's cover story on POs & PHOs picks up where the April 1993 issue of Michigan Medicine left off, providing broader, more indepth coverage of the major issues associated with PO and PHO development. Included are: an overview from MSMS Executive Director William E. Madigan; an update by Fred E. Patterson, MD, on the many important activities undertaken by the MSMS Physician Organizations Committee; a report from health care consultant Tom Gorey on some of the special organizational issues that arise when forming POs and PHOs, plus an analysis of the various PO/PHO organizational models; a descriptive and insightful article by health care consultant and futurist Jeff Goldsmith about the "baggage" physicians and hospitals bring to the "arrange marriage" of the integrated health care system; an indepth summary of the Spring PO/PHO Conference held at MSMS headquarters in May; and finally, important information on the Fall PO/PHO Conference slated for September 10-11 in Southfield. This expanded cover story begins on page 30.



Page 30

#### OTHER KEY ARTICLES

16

#### Reflections on the AMA House of Delegates Meeting

By Peter A. Levine, Executive Director, Genesee County Medical Society

#### 17

#### A Report from MSMS Alliance President Virginia Mehregan

"Working together, MSMS and the MSMS Alliance can do great things," she says.

#### 19

#### **MSMS Annual Scientific Meeting Preview**

#### 25

#### **MSMS AIDS Provider Education Project**

This informative report provides an update on the activities of the MSMS AIDS Provider Education Project, plus a variety of facts on AIDS in Michigan.

#### 52

#### **Medicine People**

This month's "Medicine People" profiles a Grand Rapids physician who breeds turtles, a retiring county medical society executive secretary, and the recently-elected president of the Michigan Association of Hospital Auxiliaries.

By Claudia Skutar and Ralph D. Ward

#### 55

#### Immunizations: Physicians Must Act Now to Ensure All Children Are Properly Immunized

This "must read" article provides a wealth of practical information on immunizations.

By Howard Weinblatt, MD

#### 62

#### **Board of Medicine Actions**

#### DEPARTMENTS

- 7 MSMS ON THE MOVE
- 9 REIMBURSEMENT ROUNDUP
- 11 MSMS LEGAL BRIEFS
- 15 RISK MANAGEMENT EXCHANGE
- 59 NEW MEMBERS
- **64 MEETINGS**
- 69 CATEGORY I COURSES
- 77 CLASSIFIEDS
- 79 ADVERTISING INDEX
- 80 PRESIDENT'S PAGE

#### In next month's issue:

MSMS Annual Scientific Meeting Final Program Issue

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# NSNS ON THE MOVE

#### A monthly update of key MSMS activities



MSMS/MSMS Alliance to help kids learn healthy behaviors Michigan adolescents will be targeted during the 1993-1994 school year by a new MSMS and MSMS Alliance program to help them take responsibility for their lives. That's because attitudes and behaviors often can be the main determinants of health.

The project, spearheaded by MSMS President Gilbert B. Bluhm, MD, and MSMS Alliance President Virginia Mehregan, builds on a successful 1992 Detroitarea media blitz called the "City for Youth-Health" project. It ran four weeks last October on Detroit's Channel 56 and commercial stations. Programs were designed to help kids respect themselves, take responsibility for personal conduct and future health (with an emphasis on combating substance abuse), develop healthy relationships (emphasizing sexual conduct and reproductive health) and lessen the risks of violence through conflict resolution. Preventive health education is a focal point of Doctor Bluhm's 1993-1994 presidency.

A \$10,000 grant this year from the MSMS Health Education Foundation permitted reproduction of the program videos and publication of teacher/student guides. They've been mailed to 610 middle school and intermediate school districts in Michigan. Both MSMS and the MSMS Alliance will work to promote use of the videos and their messages to youth through 1993-1994.

MSMS/MPMLC conference to highlight practice parameters Development and use of medical practice parameters has become increasingly important for doctors. That's due, in part, to growing direct national and state government involvement in mandating those parameters. To help physicians better understand what they can do, MSMS will conduct an afternoon seminar next month titled "Practice Parameters: Cookbook Care or the Recipe for Ensuring Quality?" The MSMS seminar will be held Oct. 12 at the Novi Hilton, in conjunction with the Michigan Physicians Mutual Liability Company (MPMLC).

The conference will examine benefits of practice parameters, including their use in reimbursement, quality management, risk management and medical malpractice defense. Presenters include John Kelly, MD, director of the AMA Office of Quality Assurance and Medical Review, and Gordon Smith, legal counsel for the Maine Medical Association. Call the MSMS Office of Physician Education at (517) 336-5784 for details.

Closed claim review sessions can help your practice MSMS and MPMLC are offering five closed claim review sessions this month. The sessions are roundtable discussions of two actual closed Michigan malpractice cases and are specialty-specific. This month, the first four listed below pertain to orthopedic surgery, while the last one reviews two obstetrics/gynecology cases. All are morning sessions. The setting encourages group participation, with doctors exploring case issues and how to prevent them in their own practices.

They'll take place **Sept. 9** at the Grand Rapids WMU Regional Center; **Sept.** 15 at Treasure Island in Saginaw; Sept. 23 at the MPMLC Metro Office in Bloomfield Hills; Sept. 28 at MSMS East Lansing headquarters; and Sept. 29 at the Grand Rapids WMU Regional Center. Call the MSMS Office of Physician Education at (517) 336-5784 for information on these and other seminars.

For details on these and other issues call William E. Madigan, Executive Director, MSMS, 517/337-1351.

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# **MSMS** Reimbursement

# Roundup

By Joyce Nurenberg

MSMS REIMBURSEMENT OMBUDSMAN



#### BCBSM liaison tells why secondary surgeries earn half payment

If you've been wondering why secondary surgeries are paid by Blue Cross Blue Shield at 50 percent of the approved amount, you'll be interested to read the following explanation by Raymond Rebandt, MD, BCBSM professional liaison.

"BCBSM's reimbursement policy for a second surgical procedure is a long-standing policy which is based upon the following rationale:

This longstanding policy was in effect when reimbursement was related to Usual, Customary and Reasonable (UCR) charges.

BCBSM reimburses a physician for services performed (total work). The surgical fee is based upon a Relative Value Unit (RVU) system which BCBSM developed in 1980 and implemented in 1983. The RVU includes pre-operative and post-operative evaluation and services, procedure time involved, complexity of the procedure, training needed, and certain overhead costs.

Prior to the start of BCBSM's RVU payment methodology, lists of procedures were sent to community specialists (Michigan physicians) for ranking based upon the above as compared to a baseline procedure with a RVU of one.

They were also asked to rank the procedure with other procedures within their own specialty as well as to procedures outside their specialty. These relationships were then integrated by BCBSM into the RVU system.

In regard to reimbursement of the second procedure, there is less pre-operative and post-operative work for the second procedure, e.g. there is only one history and physical exam, one medical record to complete and one physician post-operative visit. BCBSM determined these services represented an average of 50 percent of the total work for the second procedure.

BCBSM reimburses the physician for the total work performed for a procedure. BCBSM is not penalizing the physician, as a lesser total service is rendered for the second procedure. The savings related to an avoided second admission, anesthetic, physicians work, etc. inure to benefit the subscriber and the account.

I would like to point out that Doctor Hsiao's study (*JAMA* Oct. 28, 1988 pg 2371-78) on preservice and postservice work notes that these represent 45 percent of the total work

for inguinal herniorraphy and 44 percent for modified radical mastectomy. This would support the appropriateness of BCBSM's historical decision to reimburse the second procedure at 50 percent.

The Resource Based Relative Value Scale (RBRVS) developed by Doctor William Hsiao was implemented for Medicare in 1992. Medicare also reimburses the second procedure at 50 percent."

#### Proper form clarified for secondary balance billing to BCBSM

Those offices statusing BCBSM for the supplementary payment after Medicare, continue to use the Michigan Health Claim Review form.

Offices billing BCBSM secondary to payers other than Medicare should submit claims on the Michigan Health Claims Benefit Form. Be sure to check the "Comp" box at the top of the claim form and put an "X" in Box 62.

#### Psychiatric diagnostic interview billing frequency defined

Procedure code 90801, "is to be billed at the start of therapy and may be rebilled after a significant break in treatment has occurred (usually three years), according to BCBSM.

(Source: BCBSM, Executive Services, contributed by Steven Berger, MD)

#### Appropriate source defined

Under the consultation section in the CPT book and the MUPC Michigan Uniform Procedure Coding (MUPC) manual, it reads, "A con-

sultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source."

An "appropriate" source is some type of other health care personnel rather than a teacher or school psychologist. The

Continued on following page

#### **Billing tip**

Paper and electronic filers to Medicare should review the September *Medicare Part B* issue which lists the active action/rejection codes. Claims rejected with an action code that is preceded by an "R" can be rebilled as a new claim rather than as a status.

#### REIMBURSEMENT ROUNDUP

Continued on following page

"appropriate" source should be able to participate in the patient's health care.

If the "appropriate" source simply tells the patient to seek medical care (even if providing a physician's name) and does not further participate in the patient's care, this would be a referral for a new patient service, not a consultation request. (Source: AMA)

#### HCFA 1500 12-90 approved for worker's compensation claims

Amendments to the Worker's Compensation Health Care Services took effect for services May 12 and after. Among the amendments, providers are now able to submit the HCFA 1500 12-90 claim form for worker's compensation services. This is an addition and does not replace other approved claim forms.

Directions for completion of the form is contained in the full amendment package and can be obtained by calling the Health Care Services Division at 517 322-5433 or writing to the address below.

If you want the February 1992 Worker's Compensation Health Care Services Rules and a copy of the amendments,

the charge is \$6.75. The check should be made out to the State of Michigan. Send name, address and check to Bureau of Workers Disability Compensation, Health Care Services Division, P.O. Box 30016, Lansing, Michigan 48909.

Do not send claims for Worker's Compensation services to this address as they do not pay for health care services. The carrier is responsible for payment and the Bureau will no longer forward claims.

#### Have Reimbursement Questions? MSMS Can Help You

MSMS Reimbursement Ombudsman Joyce Nurenberg stands ready to assist you with your reimbursement questions. Just call (517) 336-5722.

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### MSMS LEGAL BRIEFS

Editor's note: The following information is provided by MSMS legal counsel Richard D. Weber, of Kerr, Russell & Weber, Detroit. If you have a legal question you would like answered in this column, jot it down and send it to Betty McNerney.



Editor of Publications, at MSMS.

By Richard D. Weber

#### "Any Willing Provider" PPO Statute/Court Challenge

The U.S. Court of Appeals for the Fourth Circuit upheld a Virginia PPO statute with an "any willing provider" provision. The court overturned the District Court decision which held that ERISA preempts the statute. The statute provides that no health care provider willing to meet the terms and conditions offered shall be excluded from a PPO. The decision enhances the freedom of choice concept, but is criticized by the managed care industry as anti-competitive and a misunderstanding of how PPOs operate. A writ of certiorari is expected to be filed with the U.S. Supreme Court.

An estimated 14 states have "any willing provider" statutes but only a few have the broad provision. Michigan has no such statute, but there is a bill pending which would apply to pharma-

cies. These statutes have been severely criticized by the FTC as anti-competitive in that providers will have no incentive to offer maximum price discounts if they are all treated equally and managed care plans cannot assure them more business. This concept will become a major legislative and judicial issue as health care changes develop.

#### **Michigan Limited Liability Company**

Legislation creating the Michigan Limited Liability Company ("LLC") became effective on June 1, 1993. An LLC is a cross between a partnership and a corporation. It offers the tax advantages of a partnership with the personal liability protection of a corporation. It is expected to provide a new practice structure for physicians and may become the preferred vehicle in physician organizations. All members and managers of a professional LLC must be licensed and legally authorized to render the same professional service, similar to the current PC requirement.

#### Assisted Suicide Legislation/ Constitutionality

Judge Cynthia Stephens of the Wayne County Circuit Court in May entered a preliminary injunction barring the implementation of the assisted suicide legislation. She held the law void because it violated technical requirements under the Michigan Constitution and deprived terminally ill patients of a liberty interest in ending their own lives. The technical violation was based upon the Michigan Constitution which requires that no law shall embrace more than one object. The court found that this statute embraced two: a study of assisted suicide and criminalization of it. The court also

criticized the amendment process. These technical violations can be easily corrected by the legislature. Judge Stephens further opined that the U.S. Supreme Court decision in *Cruzan* creates constitutional barriers to the law. She held that the constitutional right of a competent adult to refuse medical treatment enunciated in *Cruzan* applies by analogy to the liberty interest of an individual to end life. Significantly, the Michigan Court of Appeals has recently stayed the injunction entered by Judge Stephens and the act is currently in effect.

#### HMOs/Exclusive Physician Contracting

A federal appeals court has recently upheld a New Hampshire HMO contract precluding physicians from participating in any other HMO plan. A competing HMO filed suit under the federal antitrust laws claiming the exclusivity clause represented a group boycott and monopoly, both per se violations under the Sherman Act. Physicians agreeing to the contract remained free to serve non-HMO patients under a fee-for-service arrangement, have the right to opt out upon 30 days notice and received approximately 14 percent more in reimbursement. The appellate court found no antitrust violation for the reason that the HMO's relationship with physicians was vertical, which precluded any argument of a group boycott, and for the further reason that less than 25 percent of primary care physicians in New Hampshire contracted with that HMO. The issue of exclusive HMO contracts will continue to be the subject of judicial scrutiny.

Continued on following page

Continued from page 11

#### State Bar Lobbying

On June 19, the State Bar Representative Assembly agreed with the Board of Commissioner's recommendation to discontinue general lobbying activities. This followed a decision by the U.S. Supreme Court requiring an "opt out" procedure and the subsequent 48 percent attorney rejection of payment for lobbying activities in their 1992-93 bar dues. The Representative Assembly decision must be approved by the Michigan Supreme Court, which is expected. This will fundamentally change political activities with the State Bar. It can be expected that the MTLA will take up the slack.

#### **Professional Corporations/MDs** and DOs

The Attorney General has opined that MDs and DOs may not be shareholders in the same professional corporation for the reason that they are licensed under different sections of the Public Health Code. The AG has insisted that a large orthopedic practice PC restructure. I strongly differ with the conclusions reached by the Attornev General. Although MDs and DOs are licensed under separate sections of the Public Health Code, they are both authorized to practice the full scope of medicine, including diagnosis, treatment and prescription. The Professional Services Corporation Act reguires all shareholders to be "licensed or legally authorized in this state to render the same professional service." MDs and DOs are both legally authorized to render the same professional services. It is recommended that MSMS provide legal support to the orthopedic practice composed of MDs and DOs in opposing the AG's initiatives.

#### **Legal Counsel Meeting Recap**

The American Society of Medical Association Counsel (ASMAC) is composed of legal counsel representing state medical associations. As a member of ASMAC. I made presentations at the Association's recent annual meeting on both the new Michigan malpractice reform legislation and the physician organization initiatives by MSMS. The tort reform provisions received wide accolades, particularly the 182 day notice coupled with the affidavit of merit requirements. Considerable interest was exhibited in the MSMS physician organization initiatives. It was clear that Michigan was way out in front of other states in responding to health care delivery changes.

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Dr. David Paschall, Obstetrics/Gynecology St. Luke's Specialist Referral Network, Saginaw, MI

"I enjoy working with Dr. Starbird and his patients. I make sure he's kept up to date on any significant occurrences during pregnancy. Then, after delivery, mother and baby are sent back to him along with complete documentation on the pregnancy. There's no doubt that Dr. Starbird and I, and a lot of expectant mothers, have benefitted from our relationship through the Network."

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#### **PRACTICE PARAMETERS:**

# Cookbook Care ... ... or the Recipe for Ensuring Quality? October 12, 1993 Novi Hilton

The use of treatment guidelines by physicians and health care facilities is coming under close scrutiny with the anticipated changes resulting from National Health Care Reform. In Michigan, passage of pending legislation would enact a project similar to that recently implemented in the state of Maine, where established guidelines can be used for affirmative defense in medical malpractice cases.

**Registration Fee** - The fee for this half day seminar is \$135 for MSMS members and \$155 for non-members.

Continuing Medical Education - Stratton-Cheeseman Management Company, an organization accredited by the MSMS Committee on CME Accreditation, designates this activity meets the criteria for a maximum of 3 credit hours in Category I toward the requirements for Michigan relicensure, and of the Physician's Recognition Award of the AMA, provided it is completed as designated.

Professional Liability Insurance Merit Rating Credits-Physicians insured with MICHIGAN PHYSICIANS MUTUAL LIABILITY COMPANY who attend this program may recieve merit rating credits applicable toward a maximum of a 2 percent premium reduction. For more information, contact MPMLC at 1-800-968-2421. Physicians insured with other professional liability insurance carriers may also be eligible for premium reductions, and should contact their carriers for more information.

Presented By:

#### MICHIGAN STATE MEDICAL SOCIETY

MICHIGAN PHYSICIANS

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#### Agenda

- 1:00 p.m. Welcome and Introduction Gilbert Bluhm, MD, President Michigan State Medical Society
- 1:15 p.m. Practice Parameters-Overview and Update
  John T. Kelly, MD, Director
  Office of Quality Assurance and
  Medical Review, American Medical Association
- 2:00 p.m. Governmental Initiatives

  Barbara Fleming, MD, PhD, Senior Policy Analyst
  Agency for Health Care Policy and Research
  Washington, D.C.
- 2:45 p.m. **Break**
- 3:00 p.m. State Initiatives
  Gordon H. Smith, Legal Counsel
  Maine Medical Association

Sandra Bitonti, Manager Department of Government Relations Michigan State Medical Society

4:00 p.m. Practice Parameters and Medical Malpractice
Richard Weber, Attorney at Law
Kerr, Russell, and Weber, PC

(517) 336-5769.

- 4:30 p.m. Using "Clinical Pathways"
  Kathryn Schroeder, MD
  Associate Medical Director
  William Beaumont Hospital
- 5:00 p.m. Adjournment



| PRACTICE PARAMETERS   | October 1 | 2, 1993 | <b>Novi Hilton</b>   | Payment                            |               |  |  |  |
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# RISK MANAGEMENT EXCHANGE



# **Medical Records—Part Two**

By Julie Smith

Am I legally required to document information regarding telephone contact I have with my patients?

There is no *legal* requirement for documentation related to telephone contact with or about patients. However, failure to document pertinent information related to a patient's care, whether it occurs in your office, the hospital or via a telephone conversation, could create a significant void in the medical record. Failure to document telephone treatment interferes with the communication between all individuals involved in the patient's care, creating the opportunity for diagnostic or treatment errors. In addition, the absence of this information could seriously jeopardize the ability to use the medical record for defense purposes.

Any telephone interactions that involve instructions or advice given to patients, changes in treatment, or pertinent information regarding the patient's status should be documented in the medical record. For example, if a medical office staff member were to inform a patient about a normal test result with the stipulation that this should be repeated within a specified time frame, this interaction should be recorded in the medical record. While at the time of the interaction it may appear insignificant, should the patient fail to follow-up with the repeated study and an adverse result occur, documentation of this interaction where the patient was given this instruction could be helpful in the defense of a claim or lawsuit.

For many physicians, the arduous task of documenting the numerous daily patient telephone contacts is overwhelming, and many practitioners do not consistently follow this risk management practice. However, there are several methods to ensure that pertinent telephone interactions become a permanent part of the patient's medical record.

- For telephone calls occurring within the office, a policy should be developed and enforced which mandates that the medical record be immediately available for every telephone call with a patient in which medical or treatment information is given. This will allow for documentation to be made without delay.
- Information regarding the call can be written on message paper and incorporated into the medical record. Over time, transparent tape becomes unreliable, and messages taped into the record may become lost. Pre-printed

adhesive-backed forms are an excellent way of incorporating this information into the medical record. These forms can be obtained through Abbott Press by calling (517) 336-5760.

- A pocket-sized dictaphone can be purchased, and the information dictated for future transcription and insertion into the progress notes of the medical record.
- A telephone answering machine on a designated telephone line at your office can collect dictation regarding out-of-office telephone interactions. This information can then be taken from the recorder by staff, transcribed and incorporated into the medical record. This system has advantages over the dictaphone as it allows for more timely transcription and prevents having to carry the dictaphone or misplacing the dictation tape.

Whatever method is selected, it should be used consistently by all individuals who document in the patient's medical record.

# Are there any legal requirements for who can or cannot document in the patient's medical record?

A In the past, many medical offices had policies which stated only the physician, or only the physician and nurse could document in the patient's medical record. However, such a policy creates restraints on ensuring that the medical

record contains pertinent information. For example, if the receptionist is not permitted to document in the medical record but takes a telephone call in which a mother cancels a 10-day follow-up appointment for otitis media for her five-year-old son, valuable documentation to defend a malpractice claim resulting after the child suffered hearing loss from prolonged infection would not be available. The medical office staff should be educated on the purposes of medical record documentation. They

should be given detailed instructions as to the type of information to be contained within the medical record and appropriate techniques for documenting.

Julie Smith is chief of Risk Management at MSMS.

# Have a Question About Risk Management? MSMS can help you

Michigan Medicine is pleased to feature Risk Management Exchange – a regular Michigan Medicine column which offers answers to physicians' questions about risk management. All questions and answers are reviewed by MSMS legal counsel, Richard D. Weber, of Kerr, Russell and Weber, Detroit, prior to publication. If you would like to submit questions for publication in this column, contact Julie Smith at MSMS (517) 336-5757.



# COMMENTARY

# Reflections on the AMA House of Delegates Meeting

By Peter A. Levine, MPH Executive Director Genesee County Medical Society

attended my first AMA House of delegates Meeting in June. I have successfully avoided attending in the past because of the press of Medical Society business, or that of its Answering Service or the Emergency Medical Centre. Somehow there is always a crisis to deal with during the AMA meetings. This year, however, I had no excuse, so I went. What an eye opener!

In reality, the AMA House of Delegates Meeting is one of the best organized, most complex, and most political meetings occurring anywhere. The media picked up on several things. Probably the most dramatic issue of media focus was the amendment to the AMA Bylaws, adding the words "sexual orientation" to the list of other protected categories which cannot be discriminated against. I must admit that I was amazed at the vituperative comments made by those opposing this Bylaws change. I was also amazed at the fact that with so many other issues under consideration by the AMA, relating to the future of health care, that the media would be so interested in this. The debate on the amendment Bylaws lasted longer than the debate on any other issue.

#### Sound bites

The other event which the media really focused on was the speech by Hillary Rodham Clinton. There is no point in reviewing the contents of that speech, because everyone who is interested must have read about it in a newspaper. I was amazed that she spoke in sound bites, providing no

specific information on how reform would actually occur.

There were many interesting debates. Most of my impressions of this vortex of activity revolve around watching the Michigan Delegation do its work.

The Michigan Delegation is uniquely placed within the AMA leadership and is disproportionately represented on councils. Frank B. Walker, MD, was re-elected to the AMA Board of Trustees, which brings me to one of the things which I was really amazed by.

The Michigan Delegation begins each day of the AMA Meeting with a 6:00 a.m. caucus. The purpose of the caucus meeting is to review resolutions, which will be discussed that day, and to arrange individual Delegation member responsibilities as it relates to the political campaigns ongoing at the AMA Meeting. The 6:00 a.m. meeting lasts until approximately 8:30 a.m. Each member of the Delegation provides reports on specific issues, and all the information is shared equally by all of the Delegation members. The day ends for these Delegates between 10:30 p.m. and midnight. The amount of energy and commitment that it takes to be a Delegate to the AMA is remarkable. So much of their year is spent on AMArelated activities - a week at the AMA House of Delegates Meeting and a week at the AMA Interim Meeting, as well as MSMS Board Meetings, etc.- that it is hard to convey to the uninvolved Genesee County Medical Society member, how committed these people are. It is much like watching a large family work, bicker, argue, reconcile, and continue growing together. The whole organization is led by Billy Ben Baumann, MD, who is the Delegation's Chair. Watching him work is like watching a Corsican net maker. His hands are moving in so many directions, coordinating the activities of the Delegation that nobody can follow everything that is going on. This is a very politically savvy Delegation, with a savvy leader.

#### Hard work

One other impression is how hard the entire Delegation and the MSMS staff group worked to get Doctor Walker re-elected to the AMA Board. The physicians of Michigan are very well represented by him. He is solid, well informed, and very savvy. The Delegation members were out campaigning for him every free second at the meetings, at dinners, caucuses, and in the hallways of the hotel. Plenty of Delegates would have wanted to be in Doctor Walker's place, but he deserves to be there.

I will now attend the AMA Annual Meetings on an annual basis. Next time, I will probably be less amazed by the process and more interested in the content of what is going on. It is amazing.

By the way, one of the more enjoyable moments was during a panel discussion hosted by Koakie Roberts, where she blasted Ira Magaziner for not showing up as scheduled. She said, "If the Clinton Administration decided not to send Mr. Magaziner because Hillary Clinton did so well, yesterday, they have sadly miscalculated."

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CONTRAINDICATIONS: VASERETIC is contraindicated in patients who are hypersensitive to any component of this product and in patients with a history of angioedema related to previous treatment with an angiotensin

history of angioedema related to previous treatment with an angiotensin converting enzyme inhibitor. Because of the hydrochlorothiazide component, this product is contraindicated in patients with anuria or hypersensitivity to other sulfornamide-derived drugs.

WARNINGS: General; Enalapril Maleate; Hypotension: Excessive hypotension was rarely seen in uncomplicated hypertensive patients but is a possible consequence of enalapril use in severely sall/volume depleted persons such as these beared in circums that with betterful.

sequence of enalapril use in severely salf/volume depleted persons such as those treated vigorously with diuretics or patients on dialysis.

Syncope has been reported in 1.3 percent of patients receiving VASERETIC. In patients receiving enalapril alone, the incidence of syncope is 0.5 percent. The overall incidence of syncope may be reduced by proper titration of the individual components. (See PRECAUTIONS, Drug Interactions, and ADVERSE REACTIONS). In patients with severe congestive heart failure, with or without associated renal insufficiency, excessive hypotension has been observed and may be associated with oliguria and/or progressive azotemia, and rarely with acute renal failure and/or death. Because of the potential fall in blood pressure in these patients, therapy should be started under very close medical supervirenal failure and/or death. Because of the potential fall in blood pressure in these patients, therapy should be started under very close medical supervision. Such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart or cere-brovascular disease, in whom an excessive fall in blood pressure could result in a myocardial infarction or cere-brovascular accident.

If hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses, which usually can be given without difficulty once the blood pressure has increased after volume expansion.

usually can be given without difficulty once the blood pressure has increased after volume expansion.

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis and /or larnyr has been reported in patients treated with angiotensin converting erazyme inhibitors, including enalapril. In such cases VASERETIC should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. Where there is involvement of the tongue, glottis or larynv, likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 ml. to 0.5 ml.) and/or measures necessary to ensure a patent airway, should be promptly provided. (See ADVERSE sary to ensure a patent airway, should be promptly provided. (See ADVERSE

Patients with a history of angioedema unrelated to ACE inhibitor therapy may be at increased risk of angioedema while receiving an ACE inhibitor (see also CONTRAINDICATIONS).

(see also CON I KAINDICA HONS).

Neutropenia/Agranulocytosis: Another angiotensin converting enzyme inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Marketing experience has revealed several cases of neutropenia or agranulo-cytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vas-

Cumulative effects of the drug may develop in patients with impaired with caution in severe renal disease. In patients with caution in severe renal disease, the patients with renal disease. In patients with renal disease. In patients with renal disease. In patients with impaired renal Cumulative effects of the drug may develop in patients with impaired renal

iction.

Thiazides should be used with caution in patients with impaired hepatic Imazides should be used with caution in patients with imparied nepart function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus ery-

allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Lithium generally should not be given with thiazides (see PRECAU-TIONS, Drug Interactions, Enalapri Materia and Hydrochlorothiazide). Pregnancy, Enalapri-Hydrochlorothiazide, Pregnancy, Enalapri-Hydrochlorothiazide, 1979 mg/kg/day of hydrochlorothiazide (2 ½ times the maximum human dose). At these doses, fetotoxicity expressed as a decrease in average fetal weight occurred in both species. No fetotoxicity occurred at lower doses; 30/10 mg/kg/day of enalapril-hydrochlorothiazide in rats and 10/10 mg/kg/day of enalapril-hydrochlorothiazide in mice. When used in pregnarcy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnarcy is detected, VASERFIC should be discontinued as soon as possible. (See Enalapril Malaste, Fetal/Neonatal Morbidity and Mortality, below.)

pregnancy is detected, VASERETIC should be discontinued as soon as possible. (See Enaligni Malate, Felal/Neonatal Morbidity and Mortality, below.)

Enalapril Maleate; Fetal/Neonatal Morbidity and Mortality: ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon

Writing pregistary in detaction, as possible.

The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligophydramios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and havengalactic hims development. Prematunity, intrautience growth retardation, hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure.

whether these occurrences were due to the ACL-inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of VASERITC as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no

25 10 mg mg

alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultra sound examinations should be performed to assess the intraamniotic envi

If oligohydramnios is observed, VASERETIC\* should be discon unless it is considered lifesaving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after

should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible mjury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as means of reversing hypotension and/or substituting for disordered renal function. Enalapril, which crosses the placenta, has been removed from neonatal circulation by peritoneal dialysis with some clinical benefit, and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure. the latter procedure.

No teratogenic effects of enalapril were seen in studies of pregnant rats, and rabbits. On a mg/kg basis, the doses used were up to 333 times (in rats), and 50 times (in rabbits) the maximum recommended human dose.

hydrochlorothiazide; Teratogenic Effects: Reproduction studies in the rabbit, the mouse and the rat at doses up to 100 mg/kg/day (50 times the human dose) showed no evidence of external abnormalities of the fetus due to showed no evidence of external abnormalities of the refus due to hydrochlorothiazide. Hydrochlorothiazide given in a two-litter study in rats at doses of 4 - 5.6 mg/kg/day (approximately 1 - 2 times the usual daily human dose) did not impair fertility or produce birth abnormalities in the offspring. Thiazides cross the placental barrier and appear in cord blood. Nontreatogenic Effects: These may include fetal or neonatal jaundice, throm-bocytopenia, and possibly other adverse reactions which have occurred in the adult.

the adult.

PRECAUTIONS: General: Enalapril Maleate: Impaired Renal Function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe congestive heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with angiotensin converting enzyme inhibitors, including enalapril, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or picetals. failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal

artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20 percent of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such itients renal function should be monitored during the first few weeks of

therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and
serum creatinine, usually minor and transient, especially when enalapril has
been given concomitantly with a diuretic. This is more likely to occur in
patients with pre-existing renal impairment. Dosage reduction of enalapril
and/or discontinuation of the diuretic may be required.

Evaluation of the hypertensive patient should always include assessment of renal function.

ment of renal function.

Hemodialusis Patients: Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes (e.g., AN 69°) and treated concomitantly with an ACE inhibitor. In these patients consideration should be

comitantly with an ACE inhibitor. In these patients consideration should be given to using a different type of dialysis membrane or a different class of antihypertensive agent. Hypertalemia: Elevated serum potassium (greater than 5.7 mEq/L) was observed in approximately one percent of hypertensive patients in chirical trials treated with enalapril alone. In most cases these were isolated values which resolved despite continued therapy, although hyperkalemia was a cause of discontinuation of therapy in 0.28 percent of hypertensive patients. Hyperkalemia was less frequent (approximately 0.1 percent) in patients treated with enalapril plus hydrochlorottiazide. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements and/or comitant use of potassium-sparing diuretics, potassium supplements and/or

comitant use of potassium-sparing diuretics, potassium supplements and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with enalapril. (See Drug Interactions.)

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/Anesthesia: In patients undergoing major surgery or during anes-thesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be Corrected by volume expansion.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect

repartition of the possible electrolyte imbalance should be performed at appropriate intervals All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly ortant when the patient is vomiting excessively or receiving parenteral is. Warning signs or symptoms of fluid and electrolyte imbalance, irretive of cause, include dryness of mouth, thirst, weakness, lethargy, pective of cai drowsiness, restlessness, confusion, seizures, muscle pains or cramps, mu cular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal distu bances such as nausea and vomiting.

bances such as nausea and vomting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or after prolonged therapy. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia may cause cardiac arrhythmia and may also sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Because enalapril reduces the production of aldostrone, concomitation therapy with enalapril attenuates the diuretic-induced potassium loss (see

Drug Interactions, Agents Increasing Serum Potassium).

Although any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease), chloride replacement may be required in the

treatment of metabolic alkalosis

Dilutional hyponatremia may occur in edematous patients in hot weather appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain

patients receiving thiazide therapy.

In diabetic patients dosage adjustments of insulin or oral hypoglycemic agents may be required. Hyperglycemia may occur with thiazide diuretics. Thus latent diabetes mellitus may become manifest during thiazide therapy.

The antihypertensive effects of the drug may be enhanced in the postsym-pathectomy patient.

sive renal impairment becomes evident consider withholding or

If progressive renal impairment becomes evident consider withholding or discontinuing diurietic therapy.

Thiazides have been shown to increase the urinary excretion of magnesium; this may result in hypomagnesemia.

Thiazides may decrease urinary calcium excretion. Thiazides may cause intermittent and slight elevation of serum calcium in the absence of known disorders of calcium metabolism. Marked hypercalcemia may be evidence of hidden hyperparathyroidism. Thiazides should be discontinued before carrying out tests for parathyroid function.

Increases in cholesterol and triglyceride levels may be associated with thiazide dispretic therapy.

azide diuretic therapy.

Information for Patients; Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the objection and provided they are consulted.

with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted

patients should be tool to discontinue the drug min they have consumer with the prescribing physiciane. It all patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to constitute the describing the described by the describing the described by th sulf with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sove throat, fever) which may be a sign of neutropenia.

Pregnancy: Fernale patients of childbearing age should be told about the consequences of second- and third-imiseter exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible.

NOTE: As with many other drugs, certain advice to patients being treated

URE: I physicial is a SOAD as possible.

NOTE: As with many other drugs, certain advice to patients being treated with VASERETIC is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible advance or intended of first.

adverse or intended effects.

Drug Interactions: Enalapril Maleate; Hypotension—Patients on Diuretic Therapy:
Patients on diuretics and especially those in whom diuretic therapy was recently instituted, may occasionally experience an excessive reduction of recently instituted, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapni. The possibility of hypotensive effects with enalapni can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with realapni. If it is necessary to continue the diuretic, provide medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS.)

Agents Causing Renin Release: The antihypertensive effect of enalapnil is augmented by antihypertensive agents that cause renin release (e.g., diuretics)

Other Cardiovascular Agents: Enalapril has been used concomitantly with beta adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine and prazosin without evidence of clinically significant adverse interactions.

adverse interactions. Agents Increasing Serum Potassium: Enalapril attenuates diuretic-induced potassium loss. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia they should be used with caution and with frequent provincing of serum potassium.

monitoring of serum potassium.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant enalapril and lithium and were reversible upon dis-continuation of both drugs. It is recommended that serum lithium fevels be monitored frequently if enalapril is administered concomitantly with lithium. Hydrochlorothiuzide, When administered concurrently the following drugs

may interact with thiazide diuretics:

Alcohol, barbiturates, or narcotics—potentiation of orthostatic hypotension may occur.

Antidiabetic drugs (oral agents and insulin)—dosage adjustment of the

Antidiabetic drugs (oral agents and insulin)—gosage adjustment of the antidiabetic drug may be required.

Other antihypertensive drugs—additive effect or potentiation.

Cholestyramine and colestipol resins—Cholestyramine and colestipol resins bind the hydrochlorothiazide and reduce its absorption from the gastrointestinal tract by up to 85 and 45 percent, respectively. Thiazides may be administered two to four hours before the resin when the two drugs are used concomitantly.

Corticosteroids, ACTH—intensified electrolyte depletion, particularly

hypokalemia.

hypokalemia. Pressor amines (e.g., norepinephrine)—possible decreased response to pressor amines but not sufficient to preclude their use.

Skeletal muscle relaxants, nondepolarizing (e.g., tubocurarine)—possible increased responsiveness to the muscle relaxant.

Lithium—should not generally be given with diuretics. Diuretic agents reduce the renal clearance of lithium and add a high risk of lithium toxicity. Refer to the package insert for lithium preparations before use of such preparations with VASERETIC.

Non-steroidal Anti-inflammatory Drugs—In some patients, the administration of a non-steroidal anti-inflammatory or a prefuse the diuretic natriuretic.

of a non-steroidal anti-inflammatory agent can reduce the diuretic, natriuretic, and antihypertensive effects of loop, potassium-sparing and thiazide diuretics. Therefore, when VASERETIC and non-steroidal anti-inflammatory agents are used concomitantly, the patient should be observed closely to determine if the

desired effect of the diuretic is obtained.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Enalapril in combination with hydrochlorothiazide was not mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril-hydrochlorothiazide did not produce DNA single strand breaks in an in vitro alkaline elution assay in rat hepatocytes or chromosomal aberrations in an in vito mouse

\* Registered trademark of Hospal Ltd.

106 weeks to rats at doses up to 90 mg/kg/day (150 times\* the maximum daily human dose). Enalapril has also been administered for 94 weeks to male and female mice at doses up to 90 and 180 mg/kg/day. respectively, (150 and 300 times\* the maximum daily dose for humans) and showed no evidence of car

cinogenicity. A cultibre real april maleate nor the active diacid was mutagenic in the Ames microbal mutagen test with or without metabolic activation. Enalapril was also negative in the following genotoxicity studies: rec-assay, reverse mutation assay with £. oif, sister chromatid exchange with cultured mammalian cells, and the micronucleus test with mice, as well as in an in vitin cytogenic study using mouse born emarcular to \$0.00 mg/kg/day of enalapril.

Hydrachlomithus/dic. Two-year feeding studies in mice and rats conducted under the auspices of the National Toxicology Program (NTP) uncovered no evidence of a carcinogenic potential of hydrochlorothiazide in female mice (at doses of up to approximately 600 mg/kg/day) or in male and female rats (at doses of up to approximately 100 mg/kg/day). The NTP, however, found equivocal evidence for hepatocarcinogenicity in male mice.

Hydrochlorothiazide was not genotoxic in vitro in the Ames mutagenicity assay of Salmonella Hydrochlorothiazide was not genotoxic in vitro in the Ames mutagenicity assay of Salmonella Hydrochlorothiazide was not genotoxic in vitro in Tab 1588 and in the Chinese Hamster Ovary.

Hydrochlorothiazide was not genotoxic *in vitro* in the Ames mutagenicity assay of *Salmonella* typhimumium strains TA 96, TA 100, TA 1535, TA 1537, and TA 1538 and in the Chinese Hamster Ovary (CHO) test for chromosomal aberrations, or *in vivo* in assays using mouse germinal cell chromosomes. Chinese hamster bone marrow chromosomes, and the *Drosophila* sex-linked recessive lethal trait gene. Positive test results were obtained only in the *in vitro* CHO Sister Chromatid Exchange (clastogenicity) and in the Mouse Lymphoma Cell (mutagenicity) assays, using concentrations of hydrochlorothiazide from 43 to 1300 μg/mL, and in the *Aspergillus midulans* non-disjunction assay at an unspecified concentrations.

tration.

Hydrochlorothiazide had no adverse effects on the fertility of mice and rats of either sex in studies wherein these species were exposed, via their diet, to doses of up to 100 and 4 mg/kg, respectively, prior to conception and throughout gestation.

Pregnancy, Pregnancy Categories C (first timester) and D (second and third trimesters). See WARNINGS, Pregnancy, Enalogial Maleute, Fetall/Neomatal Morbidity and Mortality.

Nursing Mothers: Enalogial Maleute, Fetall/Neomatal Morbidity and Mortality.

Nursing Mothers: Enalogial Because of the potential for serious reactions in nursing infants from either drug, a decision should be made whether to discontinue nursing or to discontinue VASERETIC, taking into account the importance of the drug to the mother. account the importance of the drug to the mother Pediatric Use: Safety and effectiveness in children

account the importance of the drug to the mother.

\*\*Pollutric Use: Safety and effectiveness in children have not been established.

\*\*ADVERSE REACTIONS: VASERETIC has been evaluated for safety in more than 1500 patients, including over 300 patients treated for one year or more. In clinical trials with VASERETIC no adverse experiences peculiar to this combination drug have been observed. Adverse experiences that they occurred, have been limited to those that have been previously reported with enalapril or backgrothership radio.

occurred, have been limited to those that have been previously reported with enalapril or hydrochlorothiazide.

The most frequent clinical adverse experiences in controlled trials were: dizziness (8.6 percent), headache (5.5 peccent), fatigue (3.9 percent) and cough (3.5 percent). Adverse experiences occurring in greater than two percent of patients treated with VASERETIC in controlled clinical trials were: muscle cramps (2.7 percent), nausea (2.5 percent), asthenia (2.4 percent), orthostatic effects (2.3 percent), importance (2.2 percent), and inarrhea (2.1 percent).

Clinical adverse experiences occurring in 0.5 to 2.0 percent of patients in controlled trials included: Body As A Whole: Syncope, chest pain, abdominal pain; Cardiouscular: Orthostatic hypotension, palpitation, tachycardia; Digestre: Vomiting, dyspepsia, constipation, flatulence, dry mouth; Nerrous/Psychiatric: Insomnia, nervousness, paresthesia, somnolence, vertigo; Stine Pruritus, rash; Other: Dyspnea, gout, back pain, arthralgia, diaphoresis, decreased libido, tinnitus, urinary tract infection.

Angioedema: Angioedema has been reported in patients receiving VASERETIC (0.6 percent). Angioedema: Angioedema associated with laryngale derima may be fatal. If angioedema of the face, extremities, lips, tongue, glottis and/or larynx occurs, treatment with VASERETIC should be discontinued and appropriate therapy instituted immediately. (See WARNINCS.)

Hypoterison: In clinical trails, adverse effects relating to hypotension occurred as follows: hypotension (0.9 percent), orthostatic hypotension (1.5 percent), other orthostatic effects (2.3 percent). In addition syncope occurred in 1.3 percent of patients. (See WARNINCS.)

Cough: See PRECAUTIONS, Cough.

Clinical Laboratory Test Findings: Serum Electrolytes: See PRECAUTIONS

Creatinine, Blood Urea Nitrogen: In controlled clinical trials minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.6 percent of patients with essential hy

Creatinine, Blood Liran Nitrogers. In controlled clinical trials minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.6 percent of patients with essential hypertension treated with VASERETIC. More marked increases have been reported in other enalapril experience. Increases are more likely to occur in patients with renal artery stenoiss, (See PRECAUTIONS).

Serum Uric Acid, Glucose, Magnesium, and Calcium: See PRECAUTIONS.

Hemoglobin and Hemalocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g percent and 1.0 vol percent, respectively) occur frequently in hypertensive patients treated with VASERETIC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1 percent of patients discontinued therapy due to anemia.

Lirer Function Tests: Rarely, elevations of liver enzymes and/or serum bilirubin have occurred. Other adverse reactions that have been reported with the individual components are listed below and, within each category, are in order of decreasing severity.

Enalapril Malacla—Enalapril has been evaluated for safety in more than 10,000 patients. In clinical trials adverse reactions which occurred with enalapril were also seen with VASERETIC. However, since enalapril has been marketed, the following adverse reactions have been reported: Body As A Whole: Anaphylacticid reactions (see PRECAUTIONS, Hemodialysis Patients); Cardiotuscular: Cardiac arrest, myocardial infarction or creerbrovascular accident, possibly secondary to excessive hypotension in high risk, patients (see WARNINGS, Hypolension); pulmonary embolism and infarction; pulmonary edema; rhythrodisturbances including atrial tachycardia and brackpacardia; atrial fibrillation; hypotension; angina pectoris, Directive: lieus, pancreatifis, hepatic failure, hepatitis (hepatolellural proyen on rechallengel or cholestatic pundice), melena, annorexia, glossitis, stomatitis, dry mouth; Hem

For more detailed information, consult your DuPont Pharma Representative or see Prescribing Information.

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# A message from MSMS Alliance President, Virginia Mehregan

# "Working together, the MSMS Alliance and MSMS can do great things."



t's done! The Michigan Legislature has finally approved a bill designed to cut health insurance costs and limit malpractice suits. Granted, it is not everything Michigan physicians asked for, but it is better than no bill at all. The Alliance played an active role in passage of the bill. Under the dedicated and relentless leadership of Mary Grace Robb. County Alliances took the liability reform video to local groups and organizations, informing the public of the need for change. Congratulations to all who worked for passage of the bill!

#### Other achievements

Working together, the MSMS Alliance and the MSMS can do great things. The Alliance joined the Medical Society last year in a continuing campaign to educate the medical community and the public about domestic violence. This year our focus is on the children of violence, both the abused child and the violent youngster.

To change a prevailing society attitude which is accepting of violence, we must do more than warn our children about television violence. We must teach youngsters about alternative methods of resolving conflicts and healthy lifestyles, and it must be done in their formative years. Because we believe in the potential of the project to teach these ideas, we are joining MSMS President Gilbert B. Bluhm, MD, in promoting the City for Youth Project.

The project uses a classroom video, a series of two-to four-minute vignettes featuring adolescents in formats ranging from documentary-style stories, to sit-coms, commercials and talk shows, designed to trigger student discussion. The topics include substance abuse, stress, depression, self esteem, conflict resolution, and AIDs. Principals of all 544 middle schools and 57 intermediate school districts in Michigan already have received the video and teacher's manual. Fifteen schools have used the video and eight have agreed to add the video to next year's curriculum.

#### Advocates for health

I have asked all county alliances and auxiliaries to approach their local middle schools and intermediate school districts to encourage use of the video as a valuable teaching tool to impressionable fifth through ninth graders. I would also like to ask physicians and spouses across the state to get involved locally as advocates for the City for Youth Project. Further information about the project and video can be obtained from Judy Marr at MSMS (517-336-5744).

<sup>\*</sup> Based on patient weight of 50 kg.

Do you work with a Dinosaur?



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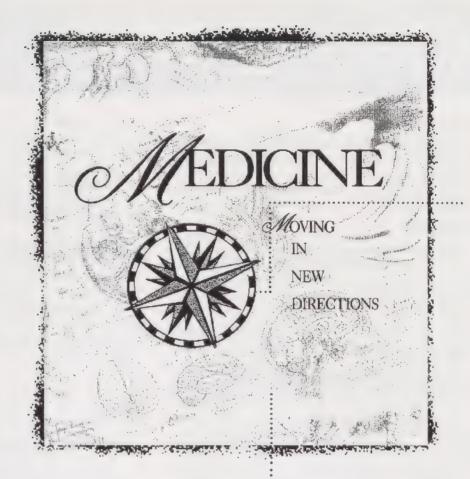
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For a free consultation please call Joan Evans at 1-800-949-8016.



# Dear Colleague:

The 1993 MSMS Annual Scientific Meeting already is gaining attention for its expanded scope, fresh directions and new location. The 128th ASM, "Medicine Moving in New Directions," is scheduled for November 9, 10 and 11, and will indeed show new directions in the quality of educational programs offered.

Expect more hands-on programs, classroom demonstrations and original presentations. There are many exciting programs being offered this year. We will have more to do, more to see, and more interactive sessions than ever before.

The new location, new scope, and new opportunities will combine to make the 1993 Annual Scientific Meeting the most enriching and enjoyable in the event's 128-year history.

Dorothy M. Kahkonen, MD Chair ASM Planning Committee



Michigan State Medical Society

1993 ANNUAL SCIENTIFIC MEETING

November 9,10 & 11, 1993

Westin Hotel, Renaissance Center, Detroit

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# MSMS Annual Scientific Meeting



## **Free Parking**

Secured parking at designated lots near the Renaissance Center will be provided free of charge to all ASM registrants. Detailed parking maps will be sent with your confirmation and parking vouchers will be presented to you at the ASM Registration Desk.

## **Free Drawing**

If you make your room reservation with the Westin Hotel before October 11, you will be entered into a drawing for a free night's stay at the Westin and a free dinnner for two at the Summit Restaurant. Call the MSMS Office of Physician Education at (517) 336-5784, to receive a hotel reservation form.

# **Adopt a Doctor Discount**

The ASM Planning Committee looks forward to continued participation by the hundreds of physicians who attend the MSMS Annual Scientific Meeting each year. Your efforts in promoting the meeting to your colleagues and the participation by more first-time attendees each year, has resulted in the Adopt-a-Doctor discount program. You may take \$20 off your registration total if you bring a physician who has never attended (or if you have never attended) an MSMS Annual Scientific Meeting.

#### **Continuing Medical Education Credits**

The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, certifies that this activity meets the criteria for a maximum of 20 credit hours in Category I toward the requirements for Michigan relicensure and of the Physicians Recognition Award of the AMA, provided it is completed as designed. Each half-day course awards 3 credit hours, and each plenary session is worth an additional 1 hour of Category 1 CME.

Traditionally these programs have been approved for prescribed credit by the American Academy of Family Physicians. Applications have been forwarded and credit approval will be indicated on the final program. For further information regarding continuing medical education or other credits for attending these courses, contact the MSMS Office of Physician Education, (517) 336-5784.

#### Over 100 Exhibits to Visit

You will want to visit the expanded Exhibit hall at the 1993 MSMS Annual Scientific Meeting. There will be exciting new educational and commercial exhibits, updated information on display, and new MSMS endorsed services to investigate. A special Practice Management Pavilion will offer free consulting advice on legal, marketing, reimburse-

ment and regulatory issues. Plus, enjoy complimentary daily refreshments and visit our new new ASM Cafe which will offer breakfast. lunch and snack items.

Exhibit hall passes are available to all Michigan physicians and their medical office staff. Two exhibit hall passes will be sent with your confirmation packet. If you need more simply call the MSMS Office of Physician Education at (517) 336-5784.

#### **Audio Cassettes Available**

For your convenience, audio cassettes of each course will be available in the MSMS Exhibit Hall, as well as by mail order following the meeting. Plan now to purchase tapes of the courses you attend, or of those courses you don't get a chance to attend. Notify your hospital or clinic librarian to suggest ordering a complete set.

# "Reclaiming the Joy of Medicine"

Take time out to provide for your own physical and mental health. Attend a special dinner presentation for physicians and their spouses entitled "Reclaiming the Joy of Medicine," sponsored by the MSMS Task Force on Physician Well-Being. This event, held at the private Detroit Renaissance Club in the Renaissance Center, will feature guest speaker, John-Henry Pfifferling, PhD, from the Center for Professional Well-Being in Durham, North Carolina. *Register for this event on the registration form on page 22*.

# "Night of 1000 Laughs"

Join your colleagues for a special evening of laughter and fun at Detroit's new "The Second City" improvisation comedy club. Just a short PeopleMover ride away, this new theater club creates a slice-of-life environment, lampooning modern lives with the use of music and laughter, instead of complicated props or costumes.

Michigan State Medical Society and the Michigan Doctors Poltical Action Committee will sponsor this "Night of 1000 Laughs." A dinner reception for conference participants, MDPAC members, community leaders and legislators begins at 6:30 p.m. The Second City performance begins at 7:30 p.m. Register for this event on the MSMS Registration Form on page 22.

# Of Special Events



# Monday, November 8, 1993

First Annual Rhoades lecture on Family Medicine "The Team Approach to the Silence of Violence: A Conference to Develop Hospital-Based Family Violence Programs"

Sponsored by MSMS Forum on Family Violence, Wayne County Medical Society and Michigan Hospital Association. Wayne County Medical Society Headquarters Program from 9:00 a.m. to 4:00 p.m. Advance Registration Suggested

# **AIDS Provider Education Update**

10:00 a.m - 4:00 p.m. Speaker Training Update

Exhibitor "Welcome" Luncheon and "The Dynamics of Medical Show Exhibiting" - open to all ASM exhibitors

12:00 Noon Lunch and Program

"Reclaiming the Joys of Medicine" by John Henry Pfifferling, PhD

Sponsored by the MSMS Task Force on Physician Well-Being Reception at 6:00 p.m. Program at 7:00 p.m. Desserts/Cordials at 8:30 p.m. *Tickets Required* 

# Tuesday, November 9, 1993

"Night of 1000 Laughs" at The Second City, Detroit Hosted by MSMS and MDPAC Heavy hors d'oeuvre Reception at 6:30 p.m. Performance at 7:30 p.m. Tickets Required

# Wednesday, November 10, 1993

MSMS Committee on Concerns of Women Physicians

12:00 noon Luncheon

# MSMS Committee of Specialty Society Presidents 12:00 noon Luncheon

Michigan Orthopaedic Society

3:00 p.m. - Board Meeting 6:00 p.m. - Reception 7:00 p.m. - Dinner

# **Michigan Society of General Surgeons**

4:00 p.m. - 6:00 p.m. Meeting and Reception

Michigan Society of Colon and Rectal Surgeons 6:30 p.m. Reception

Wayne State University School of Medicine 6:00 p.m. Alumni Reception

# Thursday, November 11, 1993

Michigan Occupational & Environmental Medical Association

6:00 p.m. Reception and Dinner

Watch for details regarding additional specialty society and alumni events in the conference final program.

Over 52 Category I CME Courses will be presented in morning (8:30 a.m. to 12:00 noon) or afternoon (1:30 p.m. to 5:00 p.m.) sessions. A complete list of these courses appears on the registration form on page 22.

A complete conference program appeared in the August 24, 1993 issue of Medigram. For further information or to receive another copy, call the MSMS Office of Physician Education at (517) 336-5784.

# 1993 MSMS Annual Scientific Meeting, November 9, 10 & 11, Westin Hotel, Renaissance Center, Detroit

| Name  |  |   | ſ  |  |  |
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| (please print)(first) (initial)   | (last)   | (title)   |  | Adopt-a-Doctor Discount*   |  |
| Street  |  |   |  | Take \$20 off your registration tota                               |  |
| City  | State  | Zip   |  | if you bring a physician who has<br>never attended (or if you have |  |
| County Phone (  | )  | _ Previous attendee?  | □ Yes □ No   | never attended) an MSMS Annua<br>Scientific Meeting.               |  |
| MSMS Member: $\square$ Yes $\square$ No $\square$ Resident $\square$ S  | Specialty  | _   |  | Your "adopted doctor" is:  |  |
| CHOOSING YOUR COURSES: Please indicas maller, hands-on courses with a higher regis  |  | Limited Attendance  | Workshops are  |  |  |
| Tuesday Morning November 9  | Wednesday Afternoon, Novem   | her 10  | Your Payment   |  |  |
| Tuesday Morning, November 9  Special "Early Bird" Plenary Session on "Health System Reform" (7:15 - 8:15 a.m., No Course Fee)  (8:30 a.m. to Noon, including break)  Basic Cardiac Life Support  50 Ways to Relieve Physician Stress and Create a Healthier Practice  Health Care Reform: What Are the Implications for My Patients and for the Future of My Medical Practice?  HIV: The Debate on Written Informed Consent Requirements  Primary Care of Injured Athletes  Radiology for Clinicians  Recognizing and Diffusing the Potentially Violent Patient  Solid Waste Management: Incineration and Landfill Use  What's New About Alzheimer's Disease?  Tuesday Afternoon, November 9  (1:30 p.m. to 5:00 p.m., including break)  Common Abdominal Problems in Children  Computers in Medicine (Basic Level) Limited Attendance Workshop  Domestic Violence - The Sequel  Life Threatening Adverse Drug Reactions  Management of Diabetes Mellitus: Impact of the DCCT  Rehabilitation of the Injured Athlete  Tuberculosis: An Old Problem with New Faces  Update on Hypertension | Computers in Medicine (Advanced Level)   |   | MSMS Members: \$55 per course MSMS Members with "retired status": \$25 per course Residents: \$25 per course Non-Members: \$75 per course Nurses: \$55 per course Students: No Course Fee Limited Attendance Workshops: \$75 per course  **NOTE: Each attendee must pay a \$20 one-time registration fee. Includes registration materials, handouts, coffee, parking, etc.  Multiply total number of half-day courses by appropriate fee: One-time Registration Fee**  x \$55 (members)  x \$55 (members)  x \$55 (members)  x \$75 (retired & residents)  x \$75 (non-members)  x \$75 (non-members)  x \$75 (Limited Attendance)  x \$75 (Limited Atten |  |  |
| Wednesday Morning, November 10  "Early Bird" Plenary Session on "Breast Cancer" (7:15 - 8:15 a.m., No Course Fee) (8:30 a.m. to Noon, including break)  Anaphylaxis: Pathophysiology, Etiology, Clinical Characteristics and Treatment  Basic Cardiac Life Support  Clinical Problems in Fluid, Electrolyte and Acid-Base Disorders  Computers in Medicine (Basic Level) Limited Attendance Workshop  Improving Physician/Patient Communication Skills  Office Management of Common Foot and Ankle Disorders  Primary Care After 50  Progress in Neurosurgery for the 21st Century (Part I)  Update on The Treatment of BPH   | Thursday Afternoon, Novemb (1:30 p.m. to 5:00 p.m., included A Multidisciplinary Approach of the Obese Patient  Common Problems in Nephr Diagnosis and Management of Embolism Diagnosis and Non-Operative Lumbar Radiculopathies Environmental Medicine for Physician Nutritional Treatment for Carlisk Factor Reduction Psychiatric Side Effects of Macdical Effects of Psychiatric Primary Care and the Educa Update in Plastic Surgery Proceedings of the State of Psychiatric Surgery Proceedings of the State of Psychiatric Primary Care and the Educa | ding break) In to Management  ology of Pulmonary  Treatment of the Practicing Indiovascular  edical Drugs and to Drugs tional System ocedures | Make checks pay Society. Mail to M 950, East Lansing ☐ Check Enclosed Charge to: ☐ Visa ☐ Card # ☐ Authorized Signat The MSMS Commit Inization accredited Accreditation, certifor a maximum of 2   | a ☐ MasterCard  Exp. Date  |  |
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Amputee Services at Rehabilitation Institute of Michigan are the most extensive in the region. They include specialized inpatient and outpatient programs for adults with amputations due to injury or medical conditions and outpatient services for children with upper or lower extremity limb loss. Our specialized myoelectric services, including the Variety Myoelectric Center for Children, provide the most advanced therapeutic techniques and prosthetic technology available.

Adult amputee patients receive high quality therapeutic services and physiatric consultations, early prosthetic fittings and patient education. These services support each of our patients' success with their prostheses. And that can make an independent lifestyle an obtainable goal.

For more information on Amputee Services at Rehabilitation Institute of Michigan or to make a referral, call (313) 745-9716.



# MSMS AIDS Provider Education Update

# OPEN LETTER FROM DOCTOR MARTIN



any people suffer from the misconception that the spread of HIV has been arrested. Unfortunately, this is not the case. Since 1982, death rates from most leading causes of death, in people 25-44 years of age, have either declined or remained constant. However, death rates due to HIV infection have continued on a steadily upward trend. According to 1991 data, HIV is the third leading cause of death for all persons 25 to 44.

In addition to the devastating effect on 25 to 44 year olds, HIV is taking an increasing toll on groups and geographic regions that had previously been unaffected by the epidemic. Heterosexual sex is one of the fastest growing HIV transmission categories. Women and teenagers are continuing to make up a greater proportion of those infected with HIV and rural communities are encountering cases of HIV.

With HIV continuing to spread, this is clearly not the time to back away from our commitment to educate everyone about HIV. When dealing with HIV/AIDS, a disease that has treatments but no cures, prevention is still our best tool. As health care providers, we must be committed to providing our patients with the accurate information they need.

Sincerely,

David B. Martin, MD, Chairman MSMS AIDS Provider Education Project

# DEMAND FOR HIV/AIDS SPEAKERS CONTINUES TO RISE

By Tracy Baker

Since 1987, the Michigan State Medical Society AIDS Provider Education Project has been providing the health care community of Michigan with accurate HIV/AIDS prevention and treatment information.

Established to achieve the educational objectives of the AIDS Provider Education Project, the AIDS/HIV Speakers Bureau continues to fill hundreds of requests for speakers each year. Available speakers include over 150 physicians, nurses, social workers, HIV test counselors, attorneys and individuals infected with HIV.

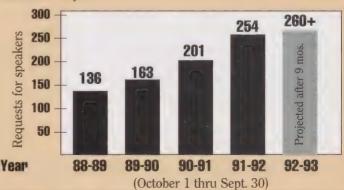
The continuing need for quality HIV educational services targeting health professionals remains apparent. The MSMS HIV/AIDS Speakers Bureau has provided over 1,100 speakers addressing over 50,000 health care providers in the last five years.

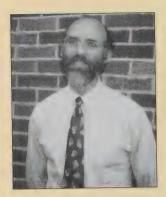
Although these numbers are extraordinary, there has been no decrease in demand. The HIV/AIDS Speakers Bureau has funded over 150 speakers in each of the last three years and it is anticipated that requests for 1993 will reach record levels. With several months left in 1993, 195 presentations already have been made and the total number of requests is expected to exceed 250 presentations.

In addition to the Speakers Bureau services, the MSMS AIDS Provider Education Project also maintains a video and slide library to assist speakers with presentations. A vast array of topics are available on slides that focus on the health care setting. These include universal precautions and infection control techniques, HIV prevention and transmission information, and special information on pediatric AIDS and HIV in women.

Less technical information is also available on videotapes. This information would be applicable to community groups, churches, schools, and other non-medical audiences. for assistance in arranging for a speaker, call Bonnie McCauley at MSMS headquarters, 517/336-1351

Tracy Baker is coordinator for the MSMS AIDS Provider Education Project.

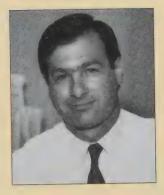




"The AIDS epidemic is not monolithic. Its considerable diversity challenges us to tailor our surveillance, prevention, and care interven-

tions to the needs of the various affected populations."

-David R. Johnson, MD, MPH Chief, Disease Control Division Bureau of Infectious Disease Control Michigan Department of Public Health



"With the eventuality of health care reform, the primary care of HIV infected persons will become more and more the responsibility of the

private medical sector. In this regard, physicians should begin to take advantage of training opportunities offered by MSMS and other health care organizations."

-Ronald M. Davis, MD Chief Medical Officer Michigan Department of Public Health

# Forum on HIV Informed Consent Requirements Planned

The issue of requiring written informed consent for HIV testing has been debated over the last few years within the Michigan State Medical Society and within the health care community. Despite the discussions to date, Michigan's health care providers remain divided over whether the laws and procedures for written informed consent should be modified or eliminated.

In an attempt to bring all necessary information to light in this debate, the MSMS AIDS Provider Education Task Force and the Michigan Department of Public Health are cosponsoring a forum on written informed consent for HIV testing at the 1993 MSMS Annual Scientific Meeting. The HIV Forum will be held the morning of November 9, 1993.

Moderated by David B. Martin, MD, Chairman, MSMS AIDS Provider Education Task Force, and Ronald M. Davis, MD, Chief Medical Officer, Michigan Department of Public Health, the program will include several presentations on the status of HIV in Michigan, laws and policies regulating HIV testing, and on the evolution of informed consent in the practice of medicine. Following the presentations, there will be a pro and con panel discussion on the issue.

# MICHIGAN AIDS FACTS

Here are a few things you may have known -- and some others that you probably did not know -about HIV and AIDS in Michigan:

Michigan is fast approaching the 5,000 mark in AIDS cases. The state had recorded 4,589 cases as of June 1, 1993; of these 2,489, or 54 percent, had died of the disease. Michigan residents continue to die of AIDS at a rate of about 10 per week.

The AIDS epidemic began about 1980, but almost a quarter of the cases recorded in Michigan by Jan. 1, 1993, were reported in 1992.

Then, in the first quarter of 1993, 886 cases were reported to the Michigan Department of Public Health – 20 percent of the cumulative total.

Statistically, this sudden increase was due to the fact that the federal Centers for Disease Control and Prevention adopted a broader case definition as of Jan. 1, 1993. New cases will not continue to be reported at this rate, but in human terms the sudden surge is nonetheless a grim reminder that many, many people are ill with HIV disease and will develop AIDS in the years ahead.

# 10,000-15,000 in state carry the AIDS virus

Surveillance experts estimate that 10,000 to 15,000 people in Michigan are currently infected with HIV, the virus that causes AIDS, and that two or three Michigan residents are being added to this pool of infection every day – about 500 to 1,000 per year. To understand what that means for our future, remember that:

- There is no vaccine against HIV, and there is no cure for AIDS. The consensus among scientists, physicians and public health experts at the recent International Conference on AIDS, held in Munich, Germany, was that we should not expect a breakthrough in either area in the foreseeable future.
- The median time from infection with HIV to development of AIDS is about 10 years. Thus, although many of today's HIV infections don't seem to burden society today, they represent an increasing and irretrievable human and economic loss to our state over the next decade.

# Heterosexual sex and drug use gain as transmission modes

Male-to-male sex has accounted for more AIDS cases than any other risk activity in the past 13 years, but male-tomale sex accounts for a smaller and smaller proportion of

"Michigan is taking major steps to address the growing rise in childbearing age women at risk of HIV/AIDS. We are currently in the process of implementing several recommendations contained in a comprehensive report released last year by the Governor's Task For on Drug Exposed Infants. Some of these policies have already resulted in a 44 percent increase in substance abuse treatment for women who use drugs or who have sex with men who use drugs."



Vernice Davis Anthony, Director Michigan Department of Public Health

# Women at Increasing Risk for HIV Infection

Not traditionally identified as a group at high risk for becoming infected with HIV, women now represent 12 percent of all AIDS cases in Michigan, and 14.1 percent of cases nationwide. This figure has been rising slowly but steadily for several years. The steady rise and the fact that 30 percent of the people in Michigan estimated to have HIV infection (but not AIDS) are women, make it seem likely that this trend will continue for the next few years.

According to data from the Centers for Disease Control, women accounted for 9.8 percent of new AIDS cases in 1992, the biggest rise of any group and dwarfing the 2.5 percent per year average increase among males. Consequently, the increasing number of HIV infected women is resulting in higher numbers of infected babies. The CDC report cites a 13.4 percent increase in children infected while in their mothers' wombs.

"This information only emphasizes the need for continuing HIV education efforts targeted at all populations, not just those traditionally known to be at risk," says David M. Martin, MD, chairman, MSMS AIDS Provider Education Task Force. "Physicians must continue to conduct thorough risk assessments with their patients, male and female."

Michigan Medicine September 1993

Michigan Medicine September 1993

new AIDS cases in Michigan. Injecting drug use and heterosexual sex represent the fastest-growing transmission categories.

Health experts warn that this presents an increasing threat to the population as a whole.

In 1992, the number of AIDS cases in Michigan associated with injecting drug use (171) was up more than a third over the average of the three previous years (123). In 1991 and 1992, a total of 66 new AIDS cases were reported related to heterosexual transmission; the total for the previous nine years was 74.

# AIDS will increase among young people

Teenagers currently represent fewer than one percent of all AIDS cases in Michigan, but they account for about four percent of the estimated cases of HIV infection.

There are other ominous signs about how the epidemic of HIV infection and AIDS will affect our young people in the years ahead:

- Survey research indicates that 70 percent of all teenagers are sexually active by the time they graduate from high school.
- The birth rates and rates of sexually transmitted diseases among teenagers in Michigan are both rising.
- Teenagers account for about 14 percent of all HIV counseling and testing (C&T) clients at publicly supported C&T sites in Michigan each year, and they represent a

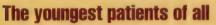
growing proportion of C&T clients found to be HIV-infected: four percent in 1992, up from two percent in 1990.

out of five people with AIDS in Michigan is 20 to 29 years old. That proportion seems likely to increase in the next decade, depriving Michigan of more and

more of its human

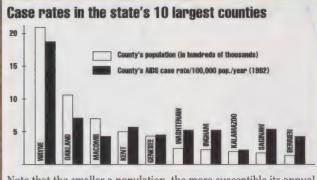
potential.

Already, one



Infants who acquired HIV from their mother before or at birth. (Patients alive as of April 1, 1993)

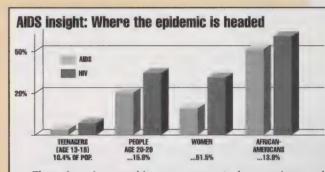
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|----------------|-------|------|-----|-----|-----|--|--|
|                |       | AIDS |     | HIV |     |  |  |
| тот            | ALS:  | 25   |     | 23  |     |  |  |
| GENDER         | M.    | 14   | 56% | 11  | 48% |  |  |
|                | F.    | 11   | 44% | 12  | 52% |  |  |
| AGE (months)   |       |      |     |     |     |  |  |
|                | 0-24  | 12   | 12% | 7   | 30% |  |  |
|                | 25-36 | 1    | 4%  | 5   | 22% |  |  |
|                | 37-48 | 2    | 8%  | 3   | 13% |  |  |
|                | 49-60 | 2    | 8%  | 3   | 13% |  |  |
|                | >60   | 8    | 32% | 5   | 22% |  |  |
| RACE ETHNICITY |       |      |     |     |     |  |  |
| Wh. non        | Hisp. | 4    | 16% | 0   | 0%  |  |  |
| Bl. non        | Hisp. | 19   | 76% | 22  | 96% |  |  |
| His            | panic | 2    | 8%  | 0   | 0%  |  |  |
| Asian A        | Amer. | 0    | 0%  | 0   | 0%  |  |  |
| Native I       | Amer. | 0    | 0%  | 0   | 0%  |  |  |
| Unk            | nown  | 0    | 0%  | 1   | 4%  |  |  |



Note that the smaller a population, the more susceptible its annual case rate to fluctuation.

#### African-Americans hard hit by disease

African-Americans make up 13.9 percent of Michigan's population. As of June 1, 1993, they represented 51.5 percent of the AIDS cases reported in the state so far and 61.0 percent of the people in Michigan known to have HIV disease (but not yet AIDS).



These four demographic groups seem to bear an increased burden of disease because they represent a higher proportion of estimated HIV cases than they do of present AIDS cases. (Chart based on data from June 1, 1993)

#### No area in Michigan will remain unscathed

The epidemic hits Southeastern Michigan and other urban centers in Michigan the hardest. Not surprisingly, Wayne County, the state's most populous, has both the largest number of AIDS cases and the highest annual rate per 100,000 residents.

However, geography provides no protection when it comes to AIDS, and counties with much smaller population centers, such as Washtenaw, Ingham, Saginaw and Berrien, bear a heavy burden of disease.

In fact, AIDS will soon reach everywhere in Michigan. As of June 1, 1992, 67 of the state's 83 counties had reported at least one case of AIDS. By June 1, 1993, the number had increased to 75.

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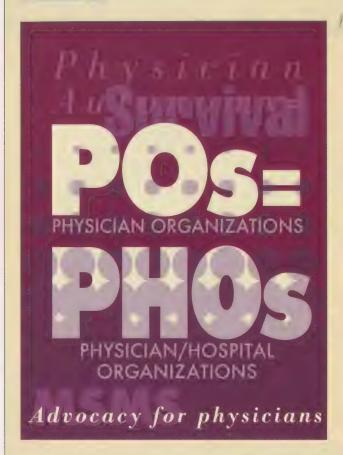
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# MSMS: Preparing Michigan Physicians for Change



By William E. Madigan, Executive Director, Michigan State Medical Society

s this issue of *Michigan Medicine* goes to press, physicians in Michigan and throughout the country still are waiting for President Clinton to announce the details of his much-delayed and anxiously anticipated health system reform proposal. However, while the Administration and Congress gear up for what is likely to be an intense, protracted debate over health care reform, significant changes nevertheless are taking place in the medical care environment, through state and private sector initiatives.

Among other things, there is a clear shift toward managed care and integrated health care delivery systems, which will require physicians to make some very important strategic decisions regarding their medical practices. In this climate of change, MSMS has taken a number of significant measures to ensure that Michigan physicians are positioned to take advantage of emerging practice development opportunities.

An important first step in this effort was the formation of a Physician Organizations Committee by the MSMS Board of Directors in October 1992. Through the efforts of this Committee, MSMS has taken an active role in educating its members about physician organizations (POs) and physician-hospital organizations (PHOs), through a series of formal spring and summer meetings and through numerous meetings with hospital medical staffs around the state.

Also, following study by the Physician Organizations Committee, MSMS has formed a consulting services group to provide hands-on assistance in the development and operation of POs and PHOs, as well as other practice development services including strategic and business planning; legal, tax, and accounting services; practice management; computer information systems; data analysis and utilization review; and risk management. The Management and Organization Services pro-

gram, which was introduced in May, promises to be a valuable addition to the ongoing array of services available by members through MSMS.

This issue of *Michigan Medicine* picks up where the April 1993 issue left off, providing broader, more in-depth coverage of the major issues associated with PO and PHO development. In the lead article, Fred E. Patterson, MD, a member of the MSMS Board of Directors and chair of the MSMS Physician Organizations Committee, highlights some of the many important activities undertaken by his committee over the past year.

Among those activities was a very successful Spring PO/PHO Conference held at MSMS headquarters on May 20, 1993. In addition to communicating to attendees

...Regardless of the ultimate outcome

of the health system reform debate.

MSMS is positioned well to provide

its members with the assistance

they will need in adjusting to changes

in our health care delivery system.

information on various topics relating to POs and PHOs, the Conference provided a valuable opportunity for members to provide input to the MSMS leadership and staff regarding ongoing and planned MSMS initiatives on this issue. An in-depth

summary of the May 20th meeting appears in this issue of *Michigan Medicine*.

In addition, this issue of *Michigan Medicine* features an outstanding series of articles dealing with the organizational and psychological issues that arise in the context of developing POs and PHOs, beginning with an article by attorney and health care consultant Tom Gorey.

In a follow-up to his PHO article which appeared in the April 1993 *Michigan Medicine*, Gorey explores in this issue some of the specific organizational issues that arise when forming POs and PHOs and analyzes various PO/PHO organizational models.

In "Driving the Nitroglycerin Truck," health care consultant and futurist Jeff Goldsmith describes in incisive terms the "baggage" that physicians and hospitals bring

to the "arranged marriage" of the integrated health care system. In his article, Goldsmith emphasizes the role of collegiality as a fundamental organizing principle and provides practical advice on steps to take—and not to take—in establishing an integrated health care organization.

Finally, this issue of *Michigan Medicine* contains important information on the September 10-11, 1993, meeting, "Physician Organizations and Physician Hospital Organizations: Cornerstones to Successful Health Care Reform." This meeting, which promises to be outstanding, will involve a national panel of experts on health system reform, managed care, POs and PHOs, including the authors of the various articles in this issue

on that topic.

The medical care environment is changing rapidly, with the potential for much greater change if the Clinton Administration is successful in securing passage of its health system reform proposal. However, re-

gardless of the ultimate outcome of the health system reform debate, MSMS is positioned well to provide its members with the assistance they will need in adjusting to changes in our health care delivery system.

On your behalf, through our Board of Directors, our Physician Organizations Committee, and our staff, MSMS has been aggressively developing educational programs to inform you of the changes that are taking place and providing consulting services to assist you in adjusting to those changes. MSMS understands the challenges that you are facing and the unique environment in which you deliver medical care. With your needs in mind, we will continue to develop programs and services to help you meet the challenges, and take advantage of the opportunities, of the future.



# MSMS Physician Organizations Committee:

# Helping Michigan Physicians Organize for the Future

By Fred E. Patterson, MD

ast year, the MSMS Board of Directors established a task force on physician-hospital organizations to explore the role of MSMS in assisting its members in adapting to a rapidly changing medical practice environment. Upon the recommendation of the task force, a standing Committee on Physician Organizations was approved at the October 1992 meeting of the MSMS Board of Directors.

Since its formation a year ago, the Physician Organizations Committee has initiated a number of activities designed to assist MSMS members in preparing for the opportunities-and challengesthat are expected to arise as a result of emerging public and private health system reform efforts. The major components of the Committee's strategy have been: (1) to educate Michigan physicians regarding physician organizations (POs) and physician-hospital organizations (PHOs) and on the potential role of POs and PHOs in positioning Michigan physicians favorably for likely changes in the health care environment; and (2) to develop a menu of consulting services that can be provided or coordinated through MSMS to meet the changing, practice-related needs of MSMS members.

#### PO/PHO educational strategy

A fundamental principle underlying the Committee's work has been that, given the rapid changes that are taking place in the health care delivery system and the likelihood of significant further changes through governmental or private initiatives, MSMS needs to take a leadership role in educating physicians on potentially valuable, long-range strategies, such as PHOs, to help ensure the long-term viability of their medical practices.

As a result, the Committee has devoted considerable energy to designing a mix of educational and communication activities to meet the needs of MSMS members. A key element of the Committee's strategy is a series of educational programs, which began with a very successful Spring PO/PHO Conference held at MSMS headquarters May 20, 1993. The meeting, which was attended by over 80 Michigan physicians, included the active participation of most members of the Physician Organizations Committee.

Through formal presentations and focus groups, this meeting provided an opportunity for the Physician Organizations Committee:

- to share important information on POs/PHOs generally and, specifically, MSMS' proactive initiatives on this issue:
- to gather important information on the needs, desires, and perceptions of Michigan physicians regarding POs/PHOs; and
- to generate grassroots physician support for the development of POs and PHOs throughout Michigan.

A summary of the May 20th meeting appears separately in this issue of *Michigan Medicine*.

A second major component of MSMS' strategy on PHOs was a series of seminars entitled, "Preparing Yourself for Health Care Reform," which were presented at various sites around the state this summer. These seminars, which were co-sponsored by the AMA, presented timely information on: state and national health system reform initiatives; private sector managed care developments; and strategies by which physicians can capitalize on likely changes in our health care delivery system.

These spring and summer meetings set the stage for MSMS' Fall PO/PHO Conference which will be held September 10-11 in Southfield. The Conference will feature a panel of national experts on the organizational, legal, and financial issues involved in developing and operating POs and PHOs. The Committee currently is considering additional educational seminars for the fall and winter on topics relating to health system reform, managed care, POs and PHOs.

Although such meetings are critical to MSMS' overall strategy on POs and PHOs, the Committee

views them as only one component of a comprehensive plan to educate Michigan physicians on this subject and to encourage physician development of POs and PHOs, as appropriate. Important additional components of the Committee's educational strategy include the following:

- continuing series of articles in *Michigan Medicine* and other MSMS publications;
- continued coverage of our PO/PHO activities in the external media, including *American Medical News*;
- continued public speaking engagements before hospital medical staffs and other audiences by MSMS staff, members of the Physician Organizations Committee, and other MSMS physician leaders; and
- possible development of audio and/or audiovisual educational materials on POs and PHOs for MSMS members.

# MSMS consulting services

As important as the educational component is to MSMS' overall strategy on POs and PHOs, the Committee consistently has believed that to create an awareness of POs and PHOs and to raise physicians' expectations, without offering hands-on assistance, would be detrimental to MSMS and its members. The Committee, therefore, pursued aggressively the idea of establishing an MSMS physician services group to provide consultation in developing POs/PHOs and in

66 The Physician Organizations Committee

is excited about the tremendous progress

MSMS has made on the issue of POs

and PHOs over the past year

and is excited about our future role

in assisting MSMS members

in organizing for change.

meeting physicians' other practice-related needs.

Following a staff assessment of feasibility, MSMS announced in May the formation of its Management and Organization Services (MOS) group, a subsidiary of MSMS that was established to meet

the growing needs of physicians for a variety of consulting services—related to both traditional medical practice as well as to participation in innovative medical care delivery models.

The services available through MOS were carefully selected to meet the varied needs of Michigan physicians, including everything from day-to-day operational and practice management matters to making and implementing long-range strategic practice deci-



Fred E. Patterson, MD, chair of the MSMS Physician Organizations Committee, moderated the Spring PO/PHO Conference held at MSMS headquarters May 20.

sions, such as whether to participate in a PO or PHO as a means of more actively pursuing opportunities for managed care contracting.

Although this program has only been in place for several months, the initial response from our mem-

bers has been very encouraging and MOS consultants currently are working with several physician groups interested in forming a PO or PHO.

The Physician Organizations Committee is excited about the tremendous progress that MSMS has made on the issue of POs and PHOs

over the past year and is excited about our future role in assisting MSMS members in organizing for change. MSMS has staked out a leadership position on this issue both in Michigan and nationally that should serve our physicians and our medical society well.

Doctor Patterson is chair of the MSMS Physician Organizations Committee.

# Physician Organizations and PhysicianHospital Organizations:

# Models for Managing Change

By Thomas M. Gorey, JD

n recent months, physician-hospital organizations (PHOs) and physician organizations (POs) have been cited with increasing frequency as strategies for responding to change in the health care environment. As with any new variation on an existing health care delivery scheme, there is some confusion surrounding the structure, function, and operation of POs and PHOs, and the distinction between PHOs and other models of so-called integrated delivery systems.

A saying that was coined in the 1980s with respect to PPOs is equally appropriate to PHOs: "If you've seen one PHO, you've seen one PHO." This underlies what may be the one truism about the new breed of integrated delivery systems: that there are no boilerplates or models that simply can be superimposed on a group of physicians and a specific hospital, without regard to the unique circumstances, history, needs, and goals of the parties involved.

Although it certainly is desirable to generate a common understanding of terms and to identify integration models that appear generally to hold more promise than others, more critical in the current climate is that there be a determined effort by the physicians and hospital involved to build consensus on what they want to accomplish through a contemplated cooperative venture. PHOs represent primarily a means to an end and, to be successful, there first must be a solid foundation represented by a common philosophy and set of goals. Assuming that agreement can be reached on the many tough economic and governance issues inherent in PHO development, an organizational model and legal structure can be put in place to meet the goals of the parties.

Integrated delivery systems have been established for a variety of purposes, but the raison d'etre of the current, "second generation" PHO is to position the participants to take maximum advantage of opportunities for managed care contracting in a local market. In addition to current incentives from business and insurers for such integration to take place, there also is the possibility that the federal government may provide a significant push in the same direction should it enact a managed competition approach to health system reform. Under such a scenario, it is likely that some PHOs could qualify as "Accountable Health Plans," thereby enabling them to compete for patient care contracts.

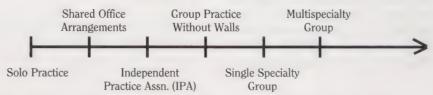
# **Horizontal Integration Options for Physicians**

Given the current instability in the health policy environment and the clear trend toward managed care approaches to health care delivery, what options are available to physicians? The range of options is limited primarily by the creativity of the physicians involved and their attorney and business advisors, as well as by the constraints posed by federal and state antitrust laws and other statutes. For physicians interested in pursuing a higher level of integration with their colleagues, there are several basic models to consider.

Figure One below graphically depicts the primary options for physician collaboration and integration.

On one end of the horizontal integration spectrum is solo practice and on the other is multispecialty group practice where, through a partnership or corporate structure, physicians from various special-

Figure 1
Physician Integration Continuum



ties combine interests and share in the profits and expenses of a medical practice. Between these two extremes, however, lie a number of viable options, including shared office arrangements, IPAs, so-called

"groups without walls," and single specialty groups.

Where are Michigan physicians today along this spectrum? According to the results of a recent MSMS survey, an estimated 48 percent of Michigan physicians are engaged in solo medical practice and 52 percent are in group practice. Of those physicians in group practice, 81 percent are in single-specialty groups and 19 percent are in multispecialty groups. In short, almost half of Michigan physicians lie on the far left end of the horizontal integration continuum (no integration), 42 percent are integrated in single specialty groups, and 10 percent are at the far right end of the integration spectrum in multispecialty groups.

As a strategy for taking advantage of opportunities for managed care contracting, a large, well-structured

multispecialty group practice offers considerable potential. Through such an arrangement, not only are the physicians able to achieve certain economies of scale, but they also are able to provide a comprehensive array of medical services to their patients and are positioned effectively to accept capitation payment if so inclined. Not surprisingly, in recent months an increasing focus has been brought to bear on some of

the larger, more well-known multispecialty medical groups around the country, including for example, the Permanente Medical Group in California and the Lovelace Physician Group in Mexico.

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Although many of these group practices provide excellent models of large-scale physician integration, with sophisticated management and organization systems, the leap from solo practice (or small, single specialty group) to large, integrated, multispecialty group is one that is not likely to occur too often or too easily. Because of the many political and practical obstacles to formation of a multi-specialty group, in most cases it is not likely to be an initial integration strategy, but rather the end result of a gradual process of physician integration which begins with much looser organizational ties. This is understandable, considering the historical development of today's large multispecialty group practices.

For example, the Permanente Medical Group gradually evolved over a period of 45 years from seven partner physicians and 18 staff physicians to approximately 2,100 partner/shareholder physicians and 1,300 non-shareholder physicians. As the size of the group has increased, so too has the sophistication of Permanente's management process and governance structure, which now

Continued on following page

# **More on Tom Gorey**



Tom Gorey is president of Policy Planning Associates, Lakewood, IL, a health care consulting firm providing services to physicians, hospitals, professional and trade associations, and other health-related organizations. Prior to establishing Policy Planning Associates, Gorey served on the staff of the American Medical

Association for 11 years in various positions, including legislative attorney, director of physician practice services,

director of long range policy analysis, and director of policy development and coordination. During his last six years at the AMA, Gorey also served as the executive secretary for the AMA Council on Long Range Planning and Development.

Prior to joining the AMA, Gorey served judicial clerkships in the Illinois Supreme Court and Illinois Appellate Court and was engaged in the private practice of law. Gorey holds a BA degree from the University of Illinois and a JD degree with honors from DePaul University College of Law, where he served as a member of the Law Review Editorial Board.

Policy Planning Associates is located at 355 Cumberland, Lakewood, Illinois 60014 (815) 459-4516. Continued from page 35

supports the delivery of medical services to approximately 2.4 million people in the San Francisco area. Similarly, the Lovelace Physician Group began 71 years ago as a two-physician partnership.

For Michigan physicians who are considering integration options, the most logical approach may be to look at their current practice arrangement and consider making a move or two to the right along the integration continuum. Consider, for example, a solo practice physician with little experience with managed care. As a means of primarily reducing overhead, but also as a possible first step toward formation of a group practice, the physician might identify several other physicians in the community who have similar practice circumstances (i.e., solo practice, with little or no managed care experience) and with whom he or she enjoys a collegial relationship, with the goal of entering into an agreement for shared office space, equipment, staff, and ancillary services.

Solely pursuing a strategy of reducing overhead, through shared office space and other arrangements, however, does little to promote practice development. Specifically, to take advantage of the burgeoning opportunities (and demand by payers) for managed care contracting, physicians who are currently independent may wish to consider the potential advantages of forming an Independent Practice Association (IPA). Through an IPA, physicians can continue to maintain independent medical practices, while availing themselves of opportunities to build their patient base through participation in managed care contracts.

Another option worth considering, though a relatively new phenomenon in the medical marketplace, is the group practice without walls or, as it is sometimes called, the clinic without walls. This term, which has been defined in various ways, is perhaps best understood as an arrangement between a heretofore unaffiliated group of physicians, whereby the physicians continue to practice in their individual offices, but have many of the benefits typically associated with group practice, including shared administrative services (e.g., group purchasing, mar-

keting, billing, collections, etc.) and negotiation of managed care contracts.

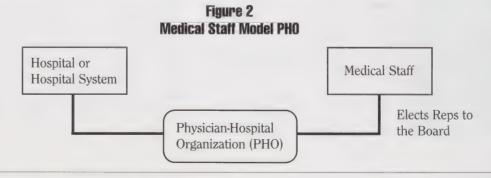
In this sense, the group without walls incorporates some of the characteristics of a traditional IPA, with the added component of shared management and administrative services. Under such an arrangement, the "group" may be marketed under a single name, with the individual physicians retaining their own revenues – following the allocation of administrative expenses across all of the participating practices. In some cases, the group without walls can become virtually indistinguishable from a traditional group practice, with the sole differentiating characteristic being that the physicians continue to practice in separate offices.

# **Physician-Hospital Integration Strategies**

In the changing health care environment, it undoubtedly will be helpful for physicians to look for possible ways to forge closer affiliations with other physicians through the formation of integrated physician organizations, both as a means of lowering overhead expenses and as a strategy to take advantage of expanding managed care contracting opportunities. Equally important for physicians, however, will be the forging of closer affiliations with their primary hospital, through formation of a physician-hospital organization (PHO) or other cooperative arrangement.

Assuming that a group of physicians is interested in working with their hospital to establish a PHO, how best can they proceed along that path? One of the first questions that must be addressed is whether the physicians should first form a physician organization (PO), such as an IPA. As with most of the strategic and operational issues that arise in forming a PHO, the answer is dependent largely upon the unique relationship that exists between the physicians and the hospital involved and the specific goals to be attained.

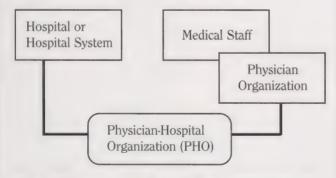
A common first step in forming a PHO is to establish a joint physician-hospital planning committee comprised of representatives of the hospital administration/board and the medical staff. Through



this committee, decisions can be made on the function. structure, and operations of the PHO. Once the PHO is established, physician participation and input into the PHO is coordinated through the participating members of the medical staff (see Figure 2). The PHO is often structured as a not-for-profit corporation, with equal representation by the hospital and physicians on the Board. Despite the apparent simplicity of the medical staff PHO model, in many cases it is advantageous for the physicians to first form a PO. First of all, a PO formed for the specific purpose of entering into a PHO arrangement with a hospital can serve as an effective vehicle for providing physician input into the governance of the PHO. Without a formal PO in place, the hospital medical staff organization becomes, de facto, the entity responsible for electing physician representatives to the PHO board, for ongoing monitoring of PHO operations, and for policymaking on PHO issues affecting physicians.

Although the medical staff may be able to assume this role, practical and political impediments often exist, some embedded in the historical role of the medical staff within the hospital. Perhaps most importantly, the medical staff is not an economic entity; its primary role is in credentialling

Figure 3
Physician Organization
Model PHO



and quality assuurance. Finally, in some hospitals, the medical staff governance process would not lend itself to efficient decision-making on the kinds of business issues that arise in the operation of a PHO.

Formation of an IPA-type PO allows a committed core of physicians, a subset of the hospital medical staff with common interests and goals, to work together on strategies designed to enhance their practices; strategies that will position them effectively as a managed care provider group. In addition to serving as a useful mechanism for providing physician representation and input into a PHO, a PO can also be an effective defense against "divide and conquer" strategies by payers and the hospital. Finally, an IPA provides the opportunity for physicians to negotiate managed care contracts with PPOs and HMOs-independent of

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Continued from page 37

the PHO-should the need or desire to do so arise.

Physicians interested in establishing a PO as a first step toward the development of a PHO, however, need to be aware of several things. First of all, the physicians involved will incur certain up-front and ongoing costs, including legal, operational, and administrative expenses. To make a commitment to a PO requires a recognition that this entity will need a Board, a committee structure, and staff support,

as well as a mechanism for credentialling, quality assurance, and utilization review. In order to be effective and to justify the costs of establishing and operating the PO, it is essential that there be active, ongoing physician involvement and an efficient and effective governance process.

Secondly, in forming a PO, there are significant legal (primarily antitrust) risks that need to be addressed. Above all, it is essential that there be a legitimate business purpose to the entity that is created. that the physicians involved are at financial risk in some way, and that the entity is not created merely as a sham to engage in price fixing. Formation of an IPA-type PO is one way to minimize potential legal problems, whereas a PO formed solely as an entity to provide input into a PHO may lack the business purpose and physician economic risk-taking required to avoid antitrust problems.

# Open vs. Closed PHO

One of the most important questions that must be addressed is whether participation in the PHO should be open to all members of the medical staff or limited to those who meet certain quality and utilization criteria. Although there may be political ramifications to excluding some physicians from participation, it may be necessary to ensure the long-term viability of the PHO.

In an open PHO, where 60 to 90 percent of the medical staff might participate, there are at least two potential problems that can arise. First, because of a lack of selectivity, the PHO may include many physicians whose utilization patterns will detract from the PHO's ability to secure and retain managed care contracts. Secondly, because hospital medical staffs typically are dominated by specialists, an open PHO may be similarly dominated. Since the effectiveness of a PHO is dependent to a large extent on the existence of a strong primary care physician base, an open PHO that

includes an overrepresentation of specialists and a dominant role by specialists in the governance of the PO and/or PHO is unlikely to be successful in the long term.

A closed PHO, on the other hand, strives to include only those physicians with a demonstrated record of providing high quality, cost-effective care. However, because of a lack of reliable, objective physician utilization data when the PHO is formed, it is unlikely that even a closed PHO initially will exclude many physicians who are interested in partici-

pating. More importantly though, forming a closed PHO sends a clear signal that utilization data will be compiled on an ongoing basis and shared with PHO physicians through periodic reports, and that the physicians who do not meet the PHO's criteria for quality and cost-effectiveness will not be recredentialled unless their practice patterns are brought into line with PHO standards. Through the periodic process of recredentialling, the physician pool can eventually be narrowed to those whose practice patterns demonstrate the kind of high quality, cost-effective care that furthers the goals of the PHO.

66 To take advantage of the burgeoning opportunities (and demand by payers) for managed care contracting, physicians who are currently independent may wish to consider the potential advantages of forming an Independent Practice Association (IPA). Through an IPA, physicians can continue to maintain independent medical practices, while availing themselves of opportunities to build their patient base through participation in managed care contracts.

#### Summary

The health care environment is expected to undergo signifi-

cant change in the coming years. The continued growth of managed care, in particular, will exert a profound impact on medical practice. This trend will be accelerated if a managed competition approach to health system reform is adopted at the federal level.

As physicians continue to consider possible strategies by which to adapt to the changing practice environment, two options may merit special consideration: first, integration with other physicians, particularly through formation of a medical group and, second, vertical integration with a hospital, through formation of a PHO. Although PHOs are a relatively recent phenomenon, they represent a potentially powerful strategy by which physicians and hospitals can combine forces to take a leadership role in managed care contracting. Through careful planning, development of a sound legal structure and efficient governance process, and implementation of effective criteria for participation in the PHO, it is possible to further the goals of the physician and hospital participants, while meeting the needs of payers.

# Physician Organizations Physician Hospital Organizations

Cornerstones to Successful Health Care Reform

Presented by
Michigan State Medical Society
in cooperation with
Michigan Physicians
Mutual Liability Company (MPMLC)

Friday Evening and Saturday September 10 and 11, 1993

Embassy Suites Hotel, Southfield, Michigan

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- Details of the Clinton Administration health system reform plan
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- Prospects for Congressional action

## This conference will discuss:

- What are POs/PHOs?
- How do they relate to health care reform?
- What legal issues must be addressed in PO/PHO development?
- Keys to the development and operation of successful POs/PHOs
- Importance of trust and collegiality in running an effective PO/PHO
- Services available to help organize and operate a successful PO/PHO

# Featured Speakers

Thomas R. Reardon, MD



Doctor Reardon is a general practitioner from Portland, Oregon, and a member of the AMA Board of Trustees. Doctor Reardon has served on the Congressional Physician Payment Review Commission (PPRC) since 1986. He was elected Vice President of the AMA Physician Health Foundation in 1992, and represented the Hospital Medical Staff Section in the AMA House of Delegates from 1983-1990. Doctor Reardon also served on the AMA steering committee which established the Hospital Medical Staff Section. A graduate from the University of Colorado School of Medicine in 1959, Doctor Reardon interned at Baltimore City Hospital until 1960 and served in the US Air Force from 1960 to 1963. He has maintained a busy general practice for 29 years.

Jeff C. Goldsmith, PhD



Jeff Goldsmith is a health care consultant and futurist. He is president of Health Futures, Inc., in Bannockburn, Illinois. Among his specialties are health services master planning, corporate strategic planning, and corporate and organizational development. He holds a masters degree in social psychology and a doctorate in sociology, both from the University of Chicago. Mr. Goldsmith's article, "Driving the Nitroglycerin Truck" is heralded as a "must read" for those considering the "arranged marriage" of the integrated health care system. He writes, "Embarking on the path of creating an integrated health care organization from a matrix of private practice is a little like driving a truck loaded with nitroglycerin along a bumpy road. Leaders without the political skills to sense the bumps in the road before they hit them will never know what happened."

Nathan Kaufman



Nathan Kaufman is president of the Kaufman Group, located in San Diego, CA. His firm specializes in assisting fee-for-service doctors succeed in a managed care environment. He has been involved in strategic planning and marketing throughout his career and specializes in strategic venture development. He has supervised and/or conducted strategic marketing plans for more than 250 hospitals and physician offices, including Hospital Corporation of America, St. John's Medical Center in Santa Monica, CA, and Orlando Regional Medical Center. In addition to his consulting activities, Mr. Kaufman is a faculty member for the American College of Healthcare Executives. Mr. Kaufman holds a masters degree in health systems from the Georgia Institute of Technology.

James G. Pitcavage, MD



Doctor Pitcavage is a practicing pediatrician at Sewickley Valley Pediatric and Adolescent Medicine, PC, in Sewickley, Pennsylvania. He has been active in organizing a regional physician hospital organization, Alpha, and a statewide physician hospital organization, Volunteer Hospitals of America. He serves on the boards of directors of both organizations. Doctor Pitcavage is chair of the Pennsylvania Medical Society's Hospital Medical Staff Section.

# Conference Agenda

Friday Evening, September 10, 1993 **Buffet and Cocktails** 6:30 p.m. Welcoming Remarks 7:30 p.m. - W. Peter McCabe, MD, Chair Michigan State Medical Society Board of Directors - Fred E. Patterson, MD, Chair MSMS Physician Organizations Committee - Frank B. Walker, MD American Medical Association Board of Trustees "Health System Reform: The Clinton Administration's Proposal and the AMA's Response" 8:00 p.m. - Thomas R. Reardon, MD, American Medical Association Board of Trustees Desserts, cordials and conversation 9:00 p.m. Saturday, September 11, 1993 8:00 a.m. Introductions and New Developments in Michigan Reform - Gilbert B. Bluhm, MD, President, Michigan State Medical Society 8:10 a.m. "Integrated Systems: Myths and Realities" - Jeff C. Goldsmith, PhD, President, Health Futures, Inc., Bannockburn, Illinois 9:10 a.m. "Keys to a Successful PHO" - Nathan Kaufman, President, The Kaufman Group, San Diego, California 10:10 a.m. "To Organize or Not to Organize" - James G. Pitcavage, MD, Sewickley Valley Pediatric and Adolescent Medicine, PC, Sewickley, Pennsylvania 10:50 a.m. Break "Early Development of a Physician Organization" 11:00 a.m. - John C. "Kevin" Sullivan, MD, Medical Director, Port Huron Hospital 11:20 a.m. "The Burns Clinic Experience" - Dave Thomas, Chief Operating Officer, Burns Clinic Medical Center, PC, Petoskey 11:40 a.m. "Models of Physician Hospital Organizations" - Thomas M. Gorey, JD, President, Policy Planning Associates, Lakewood, Illinois 12:00 noon "Common Legal Questions in PO/PHO Development" - Paul Shirilla, JD, Partner, Kerr, Russell, Weber, Detroit 12:30 p.m. Lunch MSMS Management and Organization Services 1:10 p.m. - Richard P. Horsch, MD, Vice Chair, MSMS Physician Organizations Committee 1:30 p.m. "Psychology of Physician Collaboration and Trust" - Colleen Cooper, PhD, Partner, Cambridge Consultants, Inc., Okemos Interaction with the Experts (Reardon, Goldsmith, Kaufman, Pitcavage, et al) 1:45 p.m.

Adjournment Registration Information on Reverse

- W. Peter McCabe, MD, Moderator

2:45 p.m.

# Registration

The registration fee for this 1 ½ day conference is \$225 per person for MSMS, MAOPS or MMGMA members. The non-member rate is \$325. Registration fee includes Friday's reception, dinner, desserts and cordials, Saturday's continental breakfast, refreshments, lunch and all program materials.

# Hotel Accommodations

Overnight rooms have been held at the Embassy Suites Hotel in Southfield for Friday, September 10, 1993. Individuals should make their own hotel reservations by calling (313) 350-2000 by August 17. Please identify yourself with this MSMS Conference to receive the reduced rate of \$84 single or double occupancy.

# Special Accommodations

MSMS is interested in making its programs readily accessible and usable by individuals with disabilities. Please let us know if you have special accommodation needs that would make our programs more accessible or comfortable for you.

# **Cancellation Policy**

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# Driving the Nitroglycerin Truck

By Jeff C. Goldsmith, PhD

The following article is reprinted with the permission of the author and Healthcare Forum Journal.

reating the integrated healthcare organization was 1992's most popular seminar topic. Attorneys and consultants, with transparencies (and billing sheets) flying, plied the field with the latest formula for success (remember "corpo-

rate reorganization?"). Yet these advisers often lacked not only a sense of irony but a sense of history.

As Rosemary Stevens and Paul Starr both told us, the relationship between the hospital and medical practice has been the focus of a century of conflict. The antibodies against a "takeover" of medical practice have been circulating in American medicine's system for at least four generations! Clever legal structures and slick presentations will not erase a history of suspicion and mistrust.

There is no doubt that conventional medical practice is in distress. Though average physician incomes apparently continued rising through 1991, the averages conceal regional

bloodbaths, particularly in primary care. Specialists too are facing a double whammy—reduced fees and sharply higher taxes—which will push large numbers of them, already over-leveraged and cash poor, into substantial economic difficulty.

Physicians are increasingly pressuring healthcare managers (after hours and out of earshot of their

colleagues) to bail them out-by increasing their subsidies, providing them paid administrative roles, or simply buying them out. A time of opportunity, perhaps, but it is a time of profound risk as well.

# A marriage not made in heaven

Both sides of the bizarre, sadomasochistic relationship between medical practice and management bring baggage to the "arranged marriage" of the integrated healthcare system. Since neither spouse has had enough power to control the other, passive aggression has been the principle emotional theme.

Executives bring to the marriage long-simmering but rarely expressed resentments against the perceived capriciousness of physician input into management. As a consequence, there are a lot of Walter Mitty-like fantasies of power in the current generation of healthcare managers. Some managers misread the present distress of practicing physicians as foretelling the impending triumph of management. Finally, medical practice will be subsumed under management and "those S.O.B.'s will do what they are told!" Boy, are the Walter Mittys going to be disappointed.

My University of Chicago experience taught me

this lesson early: Physicians crave order but despise authority. Long deprived of the power to influence directly the management of their institutions, physicians have resorted to guile and guerrilla warfare to win their battles. While many physicians believe they are "expert" at management by dint of their medical training, most are incapable of submitting to the authority of others, physician or non-physician. They are "smarter" than their "bosses" on each successive issue.

When they are unhappy, they whine—deafeningly. They passively resist, often with a flair and elegance that dazzles even those who disapprove of what they are doing. They agree in public and privately subvert.

They wait for temporary weakness in managers and savage them. They are easily swayed against common sense by "the last angry man" in their midst.

They are, in short, terrible employees. Ask any medical school dean or group practice CEO.

The private practice, fee-for-service framework

Continued on following page

Continued from page 43

that has both nourished and insulated medical practitioners for most of this century is dying in many communities. The fact that physicians are in distress does not mean they are emotionally prepared to surrender their autonomy or participate meaningfully in a redesigned healthcare system. In fact, frightened or angry people make awful partners in any new enterprise.

Few of the skills needed to function in an organized system are present in the contemporary generation of private practitioners. Like lifelong bachelors contemplating marriage in their fifties, these physicians often have little experience with sharing, compromise and delegation of responsibility. And, frankly, many lack the civility needed to function inside a larger organization.

The current generation of healthcare executives and physician leaders are caught in a transition from atomized entrepreneurship to an organized, collegial physician culture. It is that cultural transition—not creating new corporate entities like foundations or InterStudy's MeSH plans (and herding physicians into them)—that is the heart of the management challenge in creating an integrated healthcare organization.

## Collegiality is the key

Generations of physician leaders have sought to preserve clinical autonomy in the face of increasingly complex challenges from payers and hospitals. These fighters will not go quietly into the night. The key feature of the new integrated healthcare enterprise is not a balance of power, however, but the emergence of collegiality as the fundamental organizing principle. The essence of collegiality is tolerance and a sharing of common professional values. This trust and sharing of values is, in turn, the central precondition of the ability to share and successfully manage the economic risk of health costs.

There are not many truly integrated healthcare organizations in America, and those that come to mind, like Kaiser or Mayo, are not only unambigu-

ously physician-run but are anchored in a long tradition of collegiality. This collegiality—not who owns what, how physicians are compensated, or who works for whom—is literally what integrates them.

These organizations have functioned for three generations as a true "counter culture" within the broader context of traditional private practice. The best integrated organizations had the luxury of selecting from a larger universe the subset of physicians for whom collegiality was a higher priority than autonomy.

This was certainly the most striking impression I received several years ago as a patient at the Mayo Clinic. The facilities and administrative systems in the place were unexceptional, even a little shopworn. Yet the striking difference between Mayo and the teaching institutions with which Mayo allegedly competes was the effortlessness with which Mayo physicians collaborated with one another.

Each Mayo visit involves multiple physician evaluations under the guidance of an assigned primary physician (whose specialty depends on the primary complaint). Physicians returned their colleagues' calls within minutes and caucused in hallways on their way to and from lunch and committee meetings. The Mayo physicians revelled in collaboration, and they reached an informed consensus on what to do (supported by exceptionally rapid diagnostic test reporting).

Collegiality within an organized practice may be the only shelter physicians have from the corrosive suspicion and case-by-case second guessing of clinical decisions that have overwhelmed private practice. Collegial norms of conservative medical practice render hour-by-hour practice controls unnecessary. Formalizing these norms, creating clinical protocols to make them explicit, and explicitly linking them to clinical outcomes, is the ultimate goal of the outcomes movement in contemporary medicine. These protocols will form the backbone of any integrated system, a framework that "learns" (in Peter Senge's sense of the term) and adapts to new therapies as they become available.



# Jeff C. Goldsmith, PhD,

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# Rising from the ashes

Building an integrated healthcare organization from the entrepreneurial residue of private practice may be the graveyard of a generation of lay healthcare executives. It is clear thus far that one cannot simply impose a collegial framework or economic risk on a medical community by administrative fiat. A failure to read the political tea leaves in this sensitive area has already cost one former AHA president his job (he landed on his feet, however). Timing, accurately gauging the mood of a medical community, and creating a zone of tolerance for pluralistic relationships between the organization and its physicians are indispensable ingredients in making this transition.

The wreckage of Humana provides perhaps the best cautionary tale for integrated health system builders. It shows what comes of straddling the twin worlds of managed care and private practice.

In 1992, the year the company blew apart and divested not only its hospitals but much of its administrative staff, Humana was seven years down the same road many healthcare organizations are just now entering. Humana's leaders recognized by 1985 (the year of peak hospital operating profits) that future returns in hospital operations were not going to sustain the company's equity valuation, and they moved in managed care (placing their hospital operations in a kind of harvest posture).

Humana embarked on an integration strategy with a couple of handicaps: an authoritarian management style and poor relations with many of its medical staffs. Humana's physicians often founded new facilities in partnership with the company in rebellion against the larger medical centers in their communities, and these physicians, who remained "rebels" well into the 90s, were poor candidates for any integration strategy. Nonetheless, with a singleness of purpose characteristic of Humana, the company invested many hundreds of millions of dollars (both in health plan operating losses and disrupted hospital cash flow) in building a managed care franchise.

The seed of the company's dissolution lay in attempting to force physicians to change their behavior before they were prepared to do so. The "rebel" physicians in many Humana markets were doing well enough under the old rules to resist Humana's efforts to restrict physician activity or capitate their payment. Humana certainly did not have enough leverage to force them onto salary or into hospital-supported group practice. And their physicians had enough choices available to them to abandon Humana hospitals for their private patients, resulting in a hemorrhaging of admissions.

Weep not for Humana. Its 1.7 million health plan enrollees make it a formidable player in the managed care shootout of the 1990s. Humana has as much experience as any managed care player in addressing the care of the elderly, the biggest growth market for their product in the next 15 years. Shorn of its hospitals—along with the huge capital burden and political baggage they entailed—Humana could end the decade in a stronger position than where it began.

#### Not for the faint of heart

Embarking on the path of creating an integrated healthcare organization from a matrix of private practice is a little like driving a truck loaded with nitroglycerin along a bumpy road. Leaders without the political skills to sense the bumps in the road before they hit them will never know what happened. They will be steak tartare. The following pieces of advice have been gleaned from observing many failures:

# 1. Begin with primary care; let the specialists "be free."

Primary care physicians have thus far been those most affected by the changing payment climate. They are the practitioners most likely to have "hit the wall" in their existing practice arrangements, and therefore most able to make the tradeoff between reduced autonomy and practice stability.

The core architecture of any integrated healthcare organization is a cadre of committed primary care physicians. They are the indispensable actors in an effectively organized geographic distribution strategy, and in managed care networks. Eventually, the result of managed care growth will be the shifting of economic power in most medical communities to primary care physicians.

In many communities, the supply of new primary care physicians has dried up, and those that do exist are being snapped up by group practices and managed care plans that subsidize their incomes. The practical reality for most private practice-based health systems in these communities is that unless they can replace or expand their own primary care physician network, they are on the road to the tar pits already.

The first task on the journey to integration is creating a structure to support primary medical practice, hopefully one in which physicians are not merely employees but participants who share and exercise real power. A critical issue in creating this structure is determining whether the physicians involved can actually work together as colleagues.

Specialty physicians should be offered arm's-length assistance (practice consulting or group purchasing, for instance) in coping with practice pressures, but they should remain "free agents" until the exigencies of the managed care market (not your proselytizing) force them to accept economic risk. It would be foolish for the hospital or other healthcare organization to grandfather specialist incomes that could fall by 30 to 50 percent during the Nineties.

# 2. Encourage pluralism.

Nevertheless, specialists in the medical community must be brought to recognize that practice

Continued on following page

45

arrangements they would not tolerate for themselves must be created for the primary care physicians who send them business. Absent this tolerance, they will veto any organizational arrangements they perceive as altering the "balance of power" between the hospital and its physicians and block the emergence of an integrated enterprise.

The principal challenge of creating an integrated healthcare organization is political. Physicians of different specialties and ages will have different needs. Physician leaders must be able to widen the medical community's comfort zone sufficiently to tolerate a variety of organizational arrangements.

A perception that some physicians will be given special treatment (or competitive advantage) over others erodes the trust necessary to achieve success. Trust, not structure, is the indispensable ingredient in an integrated organization. Collegiality will not flower in an armed camp, nor in a physician community where people are constantly wondering what kind of deal the other guy got.

#### 3. Don't buy practices; merge them.

An important common denominator of the efforts underway in Sacramento and Albuquerque to create integrated physician-hospital organizations is that they are based upon voluntary mergers of practices into a larger group practice entity, not upon practice buy-outs.

A physician's interest in selling his or her practice may simply reflect a desire to harvest the maximum economic value from the franchise before it becomes worthless. By purchasing it, the hospital not only acquires another asset that is declining in its earning power but another disgruntled employee, whose economic risk has now been markedly reduced (along, perhaps, with his or her motivation). Having purchased the practice, you have shifted the physician's economic risk to you. Buying an asset that by the very fact of your purchasing it causes it to decline in value is not a good business strategy.

When other institutions offer to purchase a physician's practice, it is something of a nightmare. What you would like to do is call your competitor up and agree that neither of you will do it, but that, of course, would be an antitrust violation. The communities like Kansas City, which degenerated into a practice buy-out war several years ago, are surely not better off for having cashed out their physicians.

Offering a supportive group practice alternative to being a salaried hospital employee, one in which the physicians govern their own practice instead of working for lay management, may be a viable alternative. If "renting" physician loyalty through directorships didn't work as a long-term strategy, buying their loyalty probably won't either.

#### 4. Be patient.

It took Kaiser and Mayo more than three generations to build their organizations. You are not going to create something of lasting influence in just a few years. In many communities, it may take the retirement of a generation of existing physician leaders to make a true integrated healthcare enterprise possible. In some communities in the South and East, the existing private practice framework could survive, albeit with stresses, for at least another 10 to 15 years.

Sutter's Sacramento/Sierra Medical Group (the oldest of the new generation of groups founded by private practitioners) is eight years old, and it is a considerable distance from a completely integrated entity. Encompassing specialty services in the Sacramento/Sierra umbrella could take at least five to seven more years.

## The hospital bows out

Perhaps the most important realization of all is that creating an integrated healthcare organization from the hospital side of the physician-hospital relationship means, eventually, ceding real power to a group of physicians. Achieving real power is the ultimate cure for the passive-aggressive bad habits many physicians currently display in labor organization. The best antidote for the climate of suspicion and fear that exists in many medical communities is to cultivate physician leaders with management talent to assume ultimate leadership of the integrated enterprise.

Ironically, those lay managers who succeed in creating this new organization may have worked themselves out of a job and conveyed power, formal and informal, to a new generation of physician-managers who may be the heirs of our industry.

The architecture of health systems is not founded on physical assets like hospitals or health centers but on organizations of health services professionals. The core enterprise of most existing integrated healthcare systems—Mayo, Kaiser, Henry Ford—is a large multispecialty group practice.

One thing becomes clear from studying the small number of integrated healthcare organizations we have today: In them, the hospital is truly the ancillary service—a capital-hungry, troubled cost center. The hospital is certainly not the nucleus of an integrated healthcare organization; it is instead a high maintenance core asset, whose use must be rigorously limited in managed care arrangements. Those who seek to organize integrated healthcare systems are, unwittingly perhaps, the heralds of a post-hospital era of health care delivery.

# MSMS Spring PO/PHO Conference

# Provided a Wealth of Information for Michigan Physicians



More than 80 Michigan physicians attended the Spring PO/PHO Conference held at MSMS headquarters May 20.

s part of its overall strategy to assist MSMS members in preparing for health care reform, the MSMS Physician Organizations Committee sponsored a Conference on Physician Organizations (POs) and Physician Hospital Organizations (PHOs) May 20, 1993 at MSMS Headquarters. The meeting was attended by more than 80 Michigan physicians who either are actively involved in the development of the PO or PHO or who are considering becoming involved.

The meeting was organized into three major components: an opening session consisting of formal presentations, a series of focus groups, and a closing session during which the participants shared the highlights of the discussions from the small group meetings. This article presents a summary of the presentations and discussions that took place during the meeting.

### **General Session**

Fred E. Patterson, MD, chair of the MSMS Physician Organizations Committee, opened the meeting by discussing the developments that led to the formation of the Committee and by providing an overview of the broad range of MSMS activities relating to POs and PHOs, including a planned series of meetings to be held throughout the state this summer and a major fall conference to be held September 10-11 in Southfield.

Doctor Patterson served as a moderator for the general session, introducing Thomas R. Reardon, MD, AMA Board of Trustees; John C. "Kevin" Sullivan, MD, vice president for Medical Affairs, Port

Huron Hospital; David Hoff, MD, medical director, Akron City Health System PHO; Paul M. Shirilla, JD, attorney, Kerr, Russell, and Weber; and John Richards, manager, MSMS Subsidiary Operations.

Doctor Reardon presented the following key message: There is going to be change in our health care system, but change represents an opportunity for physicians to enhance quality, improve efficiency, and to regain some of the clinical autonomy that they have lost in recent years. Doctor Reardon also highlighted the four key elements that he believes will be present in whatever future health care system emerges: accountability, predictability, efficiency, and cooperation.

First, there will be more accountability for physicians generally. Data on clinical outcomes will be readily available and will be disseminated widely. In addition, physicians increasingly will be placed at risk for the costs of delivering medical care. As part of this expanded accountability, physicians will need to be especially attentive to patient satisfaction.

The desire for predictability of costs, quality and outcomes will also drive change in the system, according to Doctor Reardon. In particular, business interests want—and will demand—more certainty concerning what their health care costs will be. Whether acting independently or in cooperation with other employers in their geographic area, employers will be asking for bids on health care coverage for a specified number of "lives" for periods of one to three years, often through direct contracting arrangements with providers.

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Thomas R. Reardon, MD, AMA Board of Trustees, provided conference attendees with an overview of federal and state health care reform developments.

Continued from page 47

There will no longer be, in Doctor Reardon's words, an "open checkbook" for health care services. In the future, efficiency will be an even more critical component in the success of physicians. Increasingly, physicians will scrutinize their practice arrangements and look for ways to become more efficient, such as by affiliating in formal group practice arrangements or by sharing administrative and support services.

Doctor Reardon also spoke of the need for cooperation among physicians, hospitals, and other elements of the health sector. Not only will cooperation enhance the ability of providers to compete effectively, but the federal government will expect cooperation.

With respect to health system reform, **Doctor** Reardon presented several scenarios that could arise if the debate over managed competition becomes prolonged: a single payer plan could emerge with renewed support; increased initiatives by the states could cause Congress to "throw up its hands" and leave the issue to the states to address; or an AHA-type proposal, with capitation and networks, could generate increased support.

Finally, Doctor Reardon discussed how POs and PHOs can empower physicians to achieve their goals and to meet the needs of their patients. Doctor Reardon referred to a recent article in *Healthcare Forum Journal* which stressed the need for collegiality among doctors and between doctors and hospitals. Without a relationship based on collegiality and trust, Doctor Reardon expressed doubt that physi-

cians would be able to compete effectively in the emerging medical practice environment.

Doctor Sullivan addressed the issue of how POs and PHOs relate to health system reform. First, he discussed several of the trends that are accelerating the movement toward POs and PHOs, including the fact that corporate purchasers of health care are organizing and developing benefit packages from which to negotiate with providers, while physicians are currently a relatively unorganized "cottage industry." Doctor Sullivan indicated that physicians need to take steps to increase their leverage in responding to corporate health initiatives.

Two important steps in this process, according to Doctor Sullivan, are: (1) physician education on POs, PHOs, health system reform, and the other major issues that are affecting medical practice, and (2) an assessment of the current practice environment to determine the point from which PO/PHO organizational efforts can begin.

Doctor Sullivan echoed Doctor Reardon's comments on the importance of trust among physicians. Doctor Sullivan indicated that a big problem currently is that physicians do not trust each other and that, without mutual trust among physicians, they cannot expect to be able to negotiate effectively with third party payers. Also, Doctor Sullivan stressed the importance of building trust between physicians and hospitals and that this will not happen overnight, but will have to be built slowly over time by beginning with small joint projects and expanding to larger ones as mutual trust grows.

In attempting to address the pressing issues confronting physicians, Doctor Sullivan stressed the need to be cognizant of fears that physicians are experiencing: fears about federal health system reform; fears about local health care developments; fears among individual physicians that they will be excluded by someone for some reason from the new delivery systems (e.g., because of the cost or quality of the services they provide or because there is a perceived oversupply of physicians in their specialty or sub-specialty); and fears that they will be "forced" to affiliate with a group of physicians.

Doctor Sullivan concluded by highlighting the key issues that need to be addressed in establishing POs and PHOs: meeting patients' needs; building trust among physicians and between physicians and hospitals; control ("the only way to get control is to give it up"); risk; exclusivity ("who's in and who's out?"); and capital.

David Hoff, MD, the medical director for the Akron City Health System PHO, discussed the key steps in the development of their PHO and discussed the goals of the PHO, including: marketing a "system

of care," contracting with HMOs and PPOs, managing capitation, providing practice support for physician practices, and developing new products and services as the need arises.

Among the strengths of the Akron City Health System PHO cited by Doctor Hoff are that the PHO is physician-directed and locally controlled and that it contracts with known, trusted sources of care (e.g., pharmacy, physical therapy, and behavioral medicine). Also critical to the success of the Akron City Health System PHO, in Doctor Hoff's opinion, was the trust that was built between the physicians and the hospital and the strong local medical management system that was established (i.e., the physicians developed their own rules and there were clearly defined provider expectations).

Paul Shirilla, an attorney with Kerr, Russell, and Weber provided an overview of the various legal issues that arise in connection with development of the PO or PHO. Shirilla indicated that POs, PHOs and other new models of health care delivery are in relatively uncharted legal waters and are establishing new legal principles on an almost case-by-case basis. Shirilla discussed the importance of strategic planning in the formation of a PO or PHO to address clinical issues, economic issues, and legal issues. In particular, Shirilla stressed the importance of practicing "preventive law" so as to avoid legal problems that may arise following formation of a PO or PHO.

Among the legal issues discussed by Shirilla that need to be considered in PO/PHO development are: 1) legal form (e.g., professional corporation, partnership, limited liability company); 2) corporate practice of medicine (e.g., can a business corporation provide health care services?); 3) insurance (e.g., is a PHO covered by state insurance laws?); 4) antitrust (to avoid antitrust problems, there needs to be a sharing of risk and a clear business purpose, and the PO or PHO must enhance, rather than hinder, competition); 5) private inurement (a not-for-profit hospital's net earnings may not be used to, or for the benefit of, any private individual or shareholder); and 6) professional liability (managed care entities may be liable for damages caused by managed care requirements).

John Richards, manager of MSMS Subsidiary Operations, described the wide variety of services available through MSMS' Management and Organization Services group to assist physicians in establishing and operating a PO and PHO. Richards provided a brief overview of the following services: strategic and business planning; organizational analysis; legal/tax; personnel management; quality assurance; data analysis; computer information systems; practice management; and financial/accounting service.

## Focus groups

A key component of the May 20th meeting was the discussions that took place among the physician participants in nine separate focus groups, each of which were facilitated by a member of the MSMS Physician Organization Committee. The focus groups provided a number of insights and perspectives that expanded the knowledge and awareness of



Harm Kraai, MD, Pontiac, (left) a focus group reporter at the Spring PO/PHO Conference, records physician comments while Fred E. Patterson, MD, (right), moderator, looks on.

the participants, but that also will be of critical importance to MSMS as it continues to refine its programs and services relating to POs and PHOs. The six questions that the focus groups were asked to address are set out below, along with a summary of the points that were raised by the focus group participants during the discussion.

# 1. What is the effect of the changing health care environment on your practice and health care in your community?

Although the physicians in the various focus groups mentioned a number of developments that are taking place in their communities, the overall sentiment expressed by the participants was uncertainty, concern, anxiety, and/or fear over the impact that health system reform will have on their practices. Physicians fear that, as a result of health system reform, their clinical autonomy may be further eroded, the physician-patient relationship may be impaired, and the financial rewards of medical practice may diminish. Many physicians expressed concern over a possible increase in government regulation and bureaucracy and a fear of increased financial risks for physicians. A number of

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Nine focus groups were held during the conference so that physicians could voice their questions and concerns about POs and PHOs on a more intimate level. H. George Levy, MD, Monroe, (right), a focus group reporter, reponds to a comment while Jerry H. Rosenberg, MD, Novi, (left) looks on.

Continued from page 49

physicians talked about the increasingly aggressive role of hospitals in staking out a competitive position for themselves, particularly through the acquisition of primary care practices. These and other actions are creating a climate of distrust between primary care physicians, specialists, and hospitals. Many physicians expressed concern over the impact all of these changes will have on quality of care. For example, one focus group member likened patients to "pawns in a chess game." The participants noted that the reaction of physicians to the changing health care environment is dependent in large part on the age of the physician; that is, physicians who are nearing retirement obviously have much less concern or anxiety than do younger physicians, who may be facing 20 or 30 years of practice as part of a new health care delivery system.

2. What is happening in your community concerning POs/PHOs and what can we learn from your experience?

As might be expected, there was a wide range of PO/PHO involvement among the physicians at this meeting. While a few indicated there is no ongoing PO/PHO developmental activity in their communities, most of the physicians indicated that there was moderate to strong interest and/or activity among the physicians in their community involving development of a PO or PHO. In some communities, the physicians are in an educational phase and in others they are in an organizational phase. In several cases, a PO has been formed and the physicians are pursuing development of a PHO. The acquisition of primary care medical practices by hospitals is straining relations between physicians and hospitals and, in some cases, is hampering efforts to form PHOs.

Some mentioned that because of mutual distrust, lack of organization, or apathy, the physicians in their communities have not yet been successful in their efforts to organize a PO. Others are struggling to overcome past bad experiences in attempting joint ventures with their hospital. It was agreed that, in order for health system reform initiatives to be successful, distrust and animosity between general practitioners and specialists, and between physicians and hospitals, has to be eliminated and a new collegial atmosphere must be fostered.

3. Discuss the ways in which POs/PHOs can help you accomplish your practice objectives.

There was strong agreement among most of the meeting participants that POs and PHOs can play a key role in helping physicians to achieve their practice objectives. Among other things, the participants mentioned that POs and PHOs can provide a proactive strategy for physician involvement in managed care: enhance the efficiency of medical care delivery by lessening physician administrative/overhead expenses and by reducing the "hassle factor"; ensure appropriate utilization and improve quality of care; increase physicians' bargaining power by reducing opportunities for pavers and hospitals to "divide and conquer"; enhance physician autonomy; and provide increased security for physicians. Some physicians viewed POs and PHOs as perhaps the only strategy left for preserving some semblance of private medical practice as they have known it.

4. What obstacles have you/might you encounter in developing POs/PHOs because of practice philosophy, relations with colleagues, and relations with hospitals?

A common theme running through the discussions on this question concerned the issue of trust—among physicians and trust between physicians and hospitals. A key component of the trust issue for physicians concerns the financial arrangements that are a critical part of establishing and operating a PO and PHO. In short, unless a compensation system is developed that is perceived as fair and workable by all of the participating physicians, a PO or PHO is not likely to get off the ground. Although the physicians seemed to acknowledge that some alteration of the current "reward" system for the various specialties is likely, several participants

expressed concern as to whether the majority of physicians are ready to support financial arrangements that may be against their short term self-interest, but necessary for the long-term benefit of physicians overall. The role of primary care physicians and specialists in a PO and PHO was identified as a particularly sensitive issue that needs to be resolved, as was the issue of which physicians are included in a PO and which are excluded. Other obstacles to PO and PHO development that were mentioned include apathy or fatalism on the part of some physicians: antitrust concerns; use of economic credentialling: required capital contribution by physicians; and perceived loss of independence by some physicians.

#### 5. What additional services can MSMS provide to assist you in developing a PO/PHO?

The participants strongly endorsed the efforts of MSMS to assist Michigan physicians in adapting to a changing medical practice environment and commented very favorably on the array of services being offered through MSMS' Management and Organization Services group. Several participants suggested that MSMS develop models or "boilerplates" that could assist physicians in PO/PHO development and help them to avoid "reinventing the wheel." One additional service that was suggested for inclusion in the MSMS consulting program was assistance in conflict resolution. A number of the participants stressed the need for ongoing workshops and seminars around the state to educate Michigan physicians on various issues related to PO/PHO development. Others emphasized the value in having MSMS screen consultants so that physicians can be assured of receiving the kinds of services they need-from consultants with the appropriate expertise. Several physicians pointed to the value in having MSMS serve as an information clearinghouse on PO/PHO developments around Michigan and in the rest of the country.

#### 6. What topics should be explored at the September PO/PHO Conference?

The participants were very supportive of the idea of a fall MSMS Conference on POs and PHOs and thought that such a meeting would attract the interest of, and be extremely helpful to, many Michigan physicians. A number of the participants sug-



Marguerite Shearer, MD, Ann Arbor, (at podium), a member of the MSMS Physician Organizations Committee and one of nine focus group leaders at the conference, presented an inspiring summary of the focus group discussions at the end of the meeting.

gested that it would be valuable to present one or more case studies illustrating the legal, financial, and organizational issues that are involved in establishing a PO or PHO and also to present several of the legal/organizational models that can be utilized. It was also suggested that information be presented on one or more POs/PHOs that have not been successful, so as to help physicians in Michigan avoid making similar mistakes. Other suggestions included having a hospital administrator or board member on the program to discuss the hospital's perspective on POs and PHOs; presenting information on the steps involved in PO/PHO development, with typical time schedules; having a workshop on negotiating skills; and including a session on computer information systems.

#### Wrap-up

Marguerite Shearer, MD, a member of the MSMS Physician Organizations Committee, presented an eloquent, inspiring summary of the meeting, in which she discussed the importance of physicians' assuming an active role in shaping their professional destiny and the future of our health care system, such as through initiation or participation in a PO and/or PHO.

The meeting concluded with the participants expressing strong support for the overall direction of MSMS activities on this issue and for continued MSMS meetings of this nature in the coming weeks and months.





When I was a kid.

I wanted to have

a better turtle pen,

and now

I've got the best.

## Kevin Dudley, MD

delivers a different type of caring to turtles

By Claudia Skutar and Ralph D. Ward

fall Michigan physicians, only one has gained attention for another type of nurturing carto turtles. Kevin Dudley, MD, a general practitioner from Grand Rapids, puts in 60 to 80 hours per week in his practice, and on staff at Blodgett Hospital. Then he returns home to his unique hobby—a 125 foot by 100 foot backyard pond system that serves as a captive breeding ground for wild turtles.

Doctor Dudley's own sub-Jurassic Park is no backyard mud puddle, either. The system required the reshaping of a large wetland area into five distinct breeding ponds, some as much as 80 feet in diameter and 10 feet deep. Docks and breeding pens make the system the only private captive breeding project of its scope in the state.

What prompts a busy physician to start such a unique, massive undertaking? Part of Doctor Dudley's fascination is caused by the jeopardy Michigan's turtle population is facing. "The Michigan turtle population has diminished in recent years" says Doctor Dudley. "Ninety-nine percent of eggs are destroyed, primarily by raccoons, whose population has increased in recent years, and three of the state's 10 turtle species are on the DNR 'special concerns' list." But Doctor Dudley's interest goes back much further. "The main reason is that I started collecting turtles as a kid. I started wandering ponds and rivers, collecting them to keep during the

winter. When I was a kid, I wanted to have a better turtle pen, and now I've got the best."

But having the best turtle pen has not come easily. When Doctor Dudley and his family moved to the Grand Rapids area in 1983, they spent a year seeking out a homesite that offered backyard turtle remodeling potential. When he found and purchased a property with a splendid swamp, just obtaining the permits to develop a pond system took over a year and a half. Then there was extensive landscaping and bulldozer work (including a stint on a mini-crane by the doctor himself when a summer drought left his ponds dying in the sun).

Despite the work, Doctor Dudley credits his youthful interest in turtles with leading him to

choose a medical career. "I was interested in the physiology of turtles. They breathe in a completely different way from other animals, and have the ability to shut off the circulation of their blood so it goes only to the most vital organs." Dudley's scientific background and dedication have led to him being one of only a handful

of state experts on Michigan turtle species, and to growing recognition as a turtle authority. He has a 45-minute talk that he delivers to nature groups, has received several state and federal grants to help with his work, and may soon publish research on the effects of soil humidity on turtle egg incubation.

Despite a flourishing medical practice and his love of turtles, Doctor Dudley structures his schedule to leave as much time as possible for his wife and three children. Beyond his medical degrees, Doctor Dudley also has a BA in Theology, and a local religious college has lately asked him to speak. The topic? Medicine, turtles, and religion. Doctor Dudley is thinking it over.

### Mary Agar

he practice of medicine has seen much change over the past 33 years, and Kalamazoo County Medical Society Executive Secretary Mary Agar has been on the job for most of them. Agar, who retires this year after 33 years with the academy, has seen a great deal of expansion since she first answered a local help wanted ad in 1960. "When I came to the academy, there were only 180 members" Agar recalls. "Now there are 546, and that's the great majority of physicians in the county. Back then it was possible to know everybody personally, but I don't know most of the new members." The Kalamazoo Academy of Medicine traces its roots to 1838, predating even the MSMS.

The professionalism required to operating a medical practice has also increased during her career. "Doctors have to deal with so many more things now, Medicare and Medicaid paperwork, and so many legal restrictions." She remembers the times before Medicare and Medicaid, so unthinkable to young practitioners today, as a simpler time. "The programs were passed in the mid-1960s, and at first we didn't notice much change. But then after a couple of years the directives for fees started coming into effect." The paperwork rush hasn't halted since.

Change in the medical profession has touched the Kalamazoo Academy of Medicine in other ways as well. "It used to be that all doctors started in solo practice," recalls Agar. "It was fun to help out the new doctors in getting set



County group has offered its members a number of eminent speakers at its major meetings, says Agar. Past speakers have included the late Theodore Cooper, MD, former chairman of the nearby UpJohn company, former Surgeon General C. Everett Koop, MD, and retired astronaut and west Michigan native Jack Lousma.

Her tenure has seen Agar become, in many ways, the soul of the Kalamazoo Academy, and she remains one of its biggest boosters. "There are real advantages to belonging; you get to see other colleagues outside the hospital setting, you get the monthly bulletin, and members receive any help they want from the office."



### Lynn Hammerstrom

s the pressures on organized medicine grow more intense, the need for a positive liaison between Michigan's hospitals and communities has never been more urgent. Meeting this need is the Michigan Association of Hospital Auxiliaries. Affiliated with the Michigan Hospital Association, MAHA offers vital support to the MHA, according to 1993-94 MAHA president Lynn Hammerstrom of Marquette.

"MAHA was formed with four goals," says Hammerstrom. "First, we provide support to the MHA and, indirectly, to the American Hospital Association. Second, we provide services such as education and training to the MAHA membership. Third, a more nebulous goal is to expand the vision and involvement of the MAHA membership. And fourth, we facilitate information flow between the auxiliary and other local health organizations."

This ambitious agenda keeps Michigan's 140 member auxiliaries hopping, according to Hammerstrom. The

Continued on following page

Continued from page 53

groups are a definite power in supporting their hospitals. In 1992, MAHA member auxiliaries raised over \$7 million, and provided 7.5 million hours of volunteer service. Members are a varied group of community people who wish to help their local hospital through fundraising, volunteer work and good community relations. "Auxilians make up a wide variety of people," she observes. "Some are strictly volunteers, some work strictly in fundraising, and some combine activities." Physician family members are usually a part of the membership at most auxiliaries.

Despite this strong crossover between the interests of med staff and the hospital, Hammerstrom, who herself is the wife of Marquette General Hospital physician and former MSMS Board member Carl F. Hammerstrom, MD, is often asked why more physicians' wives don't join the hospital auxiliary. "Personally, I think they should," she observes "even if it's only a token membership. Members of auxiliaries find it hard to understand why relatively few spouses belong." She notes that, particularly in larger communities, physicians may be on staff at several hospitals, making auxiliary membership difficult. Physicians' wives of the '90s are also more likely to have their own time-consuming careers than in years past.

MAHA has respect within the Michigan Hospital Association, with a voting seat on the MHA board. The MHA also supports the group with solid funding for MAHA's two annual meetings, for travel, and for other needed expenses. As MAHA president, Hammerstrom represents her group at board meetings. "I give representation on behalf of the MAHA, and try to convey back to our group the concerns of the MHA."

Hospital auxiliaries will play a frontline role in the debate over health care reform, according to Hammerstrom. "The health care reform arena is so wide open, all our groups are confused about what will happen. But they will play a key role in connecting hospitals to the community. We are the real link between the hospital and the community. We speak the language of both."

## Are Insurance Companies Sitting On Your Money?



- Electronic billing direct to BCBSM, Medicare & Medicaid (no clearinghouse fees)
- Hardcopy HCFA 1500 for third-party insurances
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## **Immunizations:**

## Physicians must act now to ensure all our children are immunized

By Howard Weinblatt, MD

n case you haven't heard, the United States has a record of immunizing its youngest children that would shame many third world countries. As our society reacts to the current state of our health care system and plans for its radical overhaul, one of the grossest, most indefensible failures of that system is our inability to immunize our population with vaccines that have clearly been proven safe, effective, and cost-saving. Our ability as a profession to improve this situation will be a sentinel event in our efforts to maintain influence over reconstruction of the health care system.

There are social, economic, and structural barriers to immunization. Physicians will have the most direct impact on the structural problems of vaccine delivery, but we must also understand the other barriers. We must be leaders in the fight to reduce them. What can all physicians do now to improve the situation?

#### Missed opportunities

Whether in love, finance, or immunization, there is no more poignant episode than the missed opportunity. We must cope with the evidence that half of the undervaccination of our nation's children can be attributed to physician

failure to immunize during a health care encounter.

About two-thirds of missed opportunities result from the mistaken notion that minor illness or injury precludes the administration of vaccine. True contraindications and precautions to vaccinations have been published in the *Standards for Pediatric Immunization Practices*.

The remainder of missed opportunities can probably be explained by a combination of lack of time, vaccine, materials to assure informed consent and most of all simple failure of the physician to think about immunization.

#### Each physician who cares for children should:

- 1. Have an adequate supply of properly stored vaccines available.
- 2. Have proper materials available for obtaining informed consent.
- 3. Teach all staff to review immunization status at *every* encounter.

In our office we have included a line "IMMUNIZA-TIONS UP TO DATE—Y/N" on our date-time-vital sign stamp that is used for every encounter. This simple, cheap effort has had a surprisingly large effect.

- 4. Assure that all staff including physicians understands true and false contraindications for vaccine and can explain them effectively to parents.
- 5. Arrange for immunizations to be provided without appointment if possible or at least with maximum availability and shortest waiting time.

This can be accomplished by removing needless require-

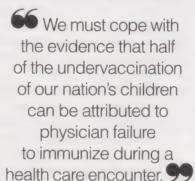
ments for comprehensive examination, temperature measurement, or physician involvement prior to vaccination. A reliable decision to vaccinate can be based on a) observing the child's general state of health, b) asking the parent or guardian if the child is well, c) asking about *true* contraindications. Physicians should provide their staff with standing orders for routine vaccination.

6. Administer multiple immunizations simultaneously if they are needed. This maneuver alone would increase immunization levels by more than 10 percent. If parents request delay in admin-

istering an additional vaccine because of the additional discomfort involved, this should be documented in the medical record and the child should have a subsequent appointment scheduled *before they leave the office*. Arrangements should be made for recall if the child fails to return

7. Set up a tracking system to recall those children who fail to come into your office for any reason during the time when they are in need of immunization. This can be a complex computer-based system or it can be something as simple and inexpensive as asking a parent to address a preprinted postcard reminder while they are waiting for their appointment. The card is then placed in the appropriate section of a little recipe box with monthly dividers. Once a month the current cards are listed then mailed out and the names checked off the list as the kids come in for their shots.

Continued on following page



Continued from page 57

- 8. Talk to your local health department about cooperative ways to improve immunization in your community. In Washtenaw County we are piloting several innovative ways to turn private physician offices into "deputized" providers of health department vaccine.
- 9. Give this article to your staff and tell them it is important to you that no child in you care goes unimmunized. Let them use their time and understanding of the special circumstances of your office to make up their own solutions to the problem.
- 10. Use every opportunity you can to communicate with leaders of religious groups, service organizations, employers, health insurers and government how strongly physicians feel about the need to improve immunization levels in this country.

#### Each hospital, emergency room, and urgent care facility should:

- 1. Have vaccines and informed consent information booklets available in the hospital pharmacy and if possible directly in the Emergency and Urgent Care areas. The answer to the argument that this would not be cost effective because so little vaccine is ordered is obvious. With better screening and understanding of vaccine contraindication myths, the demand is sure to go up.
- 2. Train staff to check and document immunization status as part of the routine admission procedure. Let them know that immunization is an important part of their mission.
- 3. Include up-to-date immunization status at discharge in your quality monitors for JCAHO accreditation both from the ward and the ambulatory clinic.
- 4. Consult with your local health department about using

your facilities to complement those of the county in providing additional sites and times for public sector immunizations.

#### Each employer, health insurer and managed health care organization should:

- 1. Review the cost effectiveness of universal immunization.
- 2. Include vaccination in the basic benefit package. This will surely be one of the first changes to come from any federal reform of the health care system.
- 3. Use immunization levels as one of your quality monitors or the subject of a health care audit.
- 4. Make high immunization levels of a primary care provider's panel a factor in determining recredentialing and economic incentives.
- 5. Consider the incentives created by making immunization and preventive health care part of capitated programs.
- 6. Consider the incentives to patients by requiring copays for immunization and preventive health care.

#### Physicians must modify social barriers

Physicians must also learn ways of modifying the social barriers to immunization. To do this we must understand the reasons that lay people choose to vaccinate or not to vaccinate and how they determine a priority for immunization with regard to other activities for promoting health and safety.

For thousands of years parents have performed some sort of rite from christening to ritual scarification which enrolled their child in the society at large. Frequently, it involved some cost, sacrifice, or even pain and danger. The practice has been so wide spread over the millennia that it must be considered an archetype of the human spirit.

#### Where to go for further information

1. Standards for Pediatric Immunization Practices; Vaccine Management: Recommendations for Handling and Storage of Selected Biologicals. Request copies from US Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Prevention Services, Division of Immunization, Atlanta, Georgia 30333

These are simple, short, straightforward guidelines for being a vaccine provider. They will be particularly useful in assuring that your staff is storing and injecting vaccines properly and encouraging them to watch out for missed opportunities.

2. American Academy of Pediatrics ACQIP (Ambulatory Care Quality Improvement Program) 1992 Vaccine series. Request copies from Publications, American Academy of Pediatrics, 141 Northwest Point Blvd., P.O. Box 927, Elk Grove Village, IL 60009-0927 or call 708/228-5005 and ask for publications.

The ACQIP is a good program for any office that cares for children. Immunization was the focus of the program in 1992 and you will have to ask for the "back issue" materials. They include exercises for you and your staff including systematic review of your procedures and directions for doing a chart audit.

**3. Esther Teich, Coordinator, Washtenaw County Immunization Initiative,** Washtenaw County Health Dept., 555 Towner, Ypsilanti, MI 48197, 313/484-7200.

Ms. Teich can supply information on some of the pilot projects being developed through a grant from the Michigan Department of Public Health and CDC.

**4. Every Child By Two,** 747 8th St., SE Washington, DC 20003, 202/544-0808. The Carter/Bumpers Campaign for Early Immunization.

A network started by former First Lady Rosalynn Carter and Betty Bumpers, wife of Arkansas Senator Dale Bumpers, to support local action plans for immunization outreach. A good source of ideas and great brochures for parents.

**5. Nancy Fasano, Special Projects Manager, Immunization Section,** Michigan Department of Public Health, P.O. Box 30035, Lansing, MI 48909, 517/335-9432.

Nancy is in charge of the Michigan Immunization Action Plan. She is an excellent source of ideas for your community to use and will also know about the process and availability of grant money for special pilots or projects.

For much of this century, the ritual of immunization had, in our secular society, taken on that function. In fact, the conquest of the great plagues of childhood diseases in the first half of this century by vaccines and the scientists who created them contributed in no small part to the ascendancy of the cult of Science at the expense of Religion and Tradition. Anyone who was school age in the 50's remembers the awesome day that the entire school lined up to receive the vaccine impregnated sugar cube on the tongue, like a communion wafer and the unspeakable joy on our mothers' faces when we returned home in a state of immunological grace.

That pretty much ended in the late sixties when a large part of a generation rebelled against the coldness and amorality of science and technology. For many parents, their job was to protect their child from flawed technology with unforseen consequences. The most cynical assumed that negative consequences were known but hidden by "the establishment" for pecuniary interest. It was as if their refusal to immunize their children was their ritual.

That pretty much ended in the eighties. Today, parents don't immunize their children mainly because they don't get around to it. Why has the priority fallen so low?

The great plagues of our children today are homicide, suicide, and intoxication, along with an infectious disease for which we have no immunization and no cure. In a study of inner city parents' attitudes toward immunization, the question "How do you keep your child healthy?" elicited a reference to immunization only once in spite of consistent mention of diet, fresh air. hygiene, and dental check ups. Describing a "good parent" included mainly issues of providing food and clothing and protection from "bad influences." Disease prevention was mentioned once with regard to chronic ear infections. In a later discussion of parent as teacher/role model medical concerns were raised but were confined to substance abuse and AIDS.

Even if these parents had more time and energy to concentrate on preventive health care it seems that they would be unlikely to invest in it. Vaccines were viewed as offering only partial protection and inflicting large amounts of pain. Several parents cited chicken pox as a disease for which immunization is available and its prevalence as proof that vaccines do not work. (Lest you belittle the poor subjects in this study. how many of your upper middle class friends think that a "flu shot" will prevent them from catching a cold?) Clinics were thought of in terms of long waits. frustration, and acute illness. There was no mention of doctors or nurses as health educators or of their role in preventive medicine.

My experience in pediatric practice suggests that these attitudes travel well beyond the inner city. Achieving complete immunization of our infants and children will require a substantial shift in the knowledge about and perceived value of these medicines as well as the health care system that supplies them. Physicians must first assure that leaders of our governments, schools, media. and communities understand the efficacy and importance of immunization. Until that has happened we must ensure that immunizations are available as easily, cheaply, frequently in as many places as possible.

References available upon request.

Doctor Weinblatt is a pediatrician and medical director of Child Health Associates, Ann Arbor, He also serves as MSMS liaison with the State Immunization Advisory Committee, MIchigan Department of Public Health.

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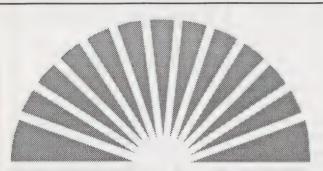
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| Sabah A. Al-Attar, MD<br>740 S. Emerick<br>Ypsilanti, MI 48198               | IM/HEM |
|--|--------|
| Michael B. Alpern, MD<br>3950 Wynnstone Dr.<br>Ann Arbor, MI 48105           | DR     |
| <b>David A. Altman, MD</b><br>11900 E. 12 Mile #201<br>Warren, MI 48093-3468 | D      |
| James K. Bischoff, MD<br>3351 Arbor Landing<br>Ann Arbor, MI 48103           | AN     |
| Marta Bonkowski, MD<br>11211 Stonybrook Dr.<br>Grand Blanc, MI 48439         | IM     |

| 2825 Windwood Dr. #19<br>Ann Arbor, MI 48105                           | PM  | 1318 Jones Dr.<br>Ann Arbor, MI 48105                                       | IM/CD |  |
|--|-----|---|-------|--|
| Roderick R. Boyd, MD<br>18234 Oak Drive<br>Detroit, MI 48221           | GS  | Philip Joseph Ferrone, MD<br>3535 W. 13 Mile Rd #632<br>Royal Oak, MI 48072 | OPH   |  |
| Julian C. Chua, MD<br>1173 N. Ballenger Hwy #203<br>Flint, MI 48504    | AN  | Scott A. Garner, MD<br>G-5020 W. Bristol<br>Flint, MI 48507                 | VS/GS |  |
| John Colombo, MD<br>22835 Kelly<br>East Pointe, MI 48021               | OPH | Mark S. Geissler, MD<br>1414 W. Fair Ave. #230N<br>Marquette, MI 49855      | PS/GS |  |
| William F. Crowley, MD<br>15855 Nineteen Mile<br>Mt. Clemens, MI 48044 | GS  | <b>Bradford C. Glezayd, MD</b> 22250 Providence #406 Southfield, MI 48075   | GE/IM |  |
| Sunil S. Desai, MD<br>6071 W. Outer Dr.<br>Detroit, MI 48235           | IM  | <b>Richard Girardi, DO</b><br>777 Kimole Lane #220<br>Adrian, MI 49221      | GS    |  |
| Paul J. Diamonti, MD<br>65 East Emmett<br>Battle Creek, MI 49017       | GS  | Sheldon Gonti, MD<br>16530 19 Mile<br>Clinton Twp, MI 48038                 | ОРН   |  |
| James F. Donahue, MD<br>3351 Landings Dr.<br>Ann Arbor, MI 48103       | AN  | <b>Anil K. Goyal, MD</b><br>3535 W. 13 Mile #632<br>Royal Oak, MI 48073     | ОРН   |  |

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The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Commerce, Office of Health Services.

Name: Younis Ahmad Asad, MD, P.O. Box 8628, Toledo, OH 43023

Action, Date Taken: License Revoked, 06-04-93

**Name:** Donald S. Chandler, MD, 1453 Bar Harbor Drive, Dallas, TX 75232

**Action, Date Taken:** Probation- until 4-19-96, Reprimand, 05-19-93

Name: Otto Graesser, DO, 1421 W. Mt. Hope, Lansing, MI 48910

**Action, Date Taken:** Probation- 2 yrs., Fine- \$1,500.00, 06-03-93

Name: Lawrence D. Holen, DO, 1655 Peppermill, Lapeer, MI 48446

**Action, Date Taken:** Reinstated w/Limited License, Probation- 2 yrs., 06-14-93

Name: Aaron J. Koenig, DO, 5784 Highland Rd., Waterford, MI 48327

**Action, Date Taken:** Probation- 1 yr., Fine- \$1,000.00, 06-03-93

Name: Roger Alvin Meharry, MD, P.O. Box 516, Rusk, TX 75785

Action, Date Taken: Probation until 2-22-96, 06-16-93

Name: Kutub H. Mesiwala, MD, 2159 Birchwood Way, Bloomfield Hills, MI 48302

Action, Date Taken: License Revoked, 07-05-93

Name: Felix K. Milton, DO, 4026 Oakwood Blvd., Melvindale. MI 48122

**Action, Date Taken:** License Permanently Surrendered, 06-08-93

Name: David M. Reed, MD, 109 S. Front St., Marquette, MI 49855

**Action, Date Taken:** Probation- 3 yrs., Fine- \$2,000.00, Reprimand, 06-18-93

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#### **Board of Medicine Actions**

Name: Tony F. Scalici, DO, 5491 S. Division, Wyoming, MI 49508

**Action, Date Taken:** Voluntary Surrender of License pending conclusion of proceedings pending in US District Court-Western District, 06-03-93

Name: Thomas M. Trueman, MD, 29829 Telegraph Rd. #100, Southfield, MI 48034

Action, Date Taken: License Suspended- 2 yrs., 06-04-93

Name: William J. Westmaas, MD, 1100 Woodward Ave. #120, Bloomfield Hills, MI 48034

**Action, Date Taken:** Limited License- 6 mo., Probation-18 mo.

Name: Henry J. Winkler, MD, 9139 Cadieux, Detroit, MI 48224

Action, Date Taken: The order issued by the Macomb County Circuit Court on 6-4-93 staying the Final Order of the Board of Medicine dated 5-10-93 was dissolved on 6-11-93. The suspension ordered by the Board will commence 6-15-93, 06-15-93

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon\* is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug. <sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally. <sup>1,3</sup>

**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence  $^{1,3,4}$  1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to  $\frac{1}{2}$  tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.

**How Supplied:** Oral tablets of Yocon\* 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

- A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
- Goodman, Gilman The Pharmacological basis of Therapeutics 6th ed., p. 176-188.
   McMillan December Rev. 1/85.

   McGelly Use Company (Artist of Company)
- Weekly Urological Clinical letter, 27:2, July 4, 1983
- A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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## **MEETINGS**

#### MSMS Meetings September

**8, 10,** MSMS Supervisory Skills Series-Part IV (Maximize Your Time, Energy and Brainpower). September 8, Troy Marriott, Troy, MI. September 10, WMU Regional Center, Grand Rapids, MI. Contact: The Office of Physician Education, (517) 336-5784.

**9, 15, 23, 28,** MSMS/MPMLC Risk Management: Closed Claim Reviews (Orthopedic Surgery). September 9, WMU Regional Center, Grand Rapids, MI. September 15, Treasure Island, Saginaw, MI. September 23, MPMLC Metro Office, Bloomfield Hills, MI. September 28, MSMS Headquarters, East Lansing, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

**10-11,** MSMS POs and PHOs: Cornerstones to Successful Health Care Reform, Embassy Suites, Southfield, MI. Contact: The Office of Physician Education, (517) 337-1351.

**13-14,** MSMS Medical Biller Training Series, MSMS Headquarters, East Lansing, MI. Contact: The Office of Physician Education, (517) 336-5784.

**15, 22, 23,** MSMS/MPMLC Diagnosis and Management of Myocardial Infarction. September 15, Grand Traverse Resort, Traverse City, MI. September 22, Novi Hilton, Novi, MI. September 23, WMU Regional Center, Grand Rapids, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

**21,** MSMS/MPMLC Fundamentals of Risk Management, Holiday Inn, Marquette, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

**23-24,** MSMS Orientation to the Medical Office, MSMS Headquarters, East Lansing, MI. Contact: The Office of Physician Education, (517) 336-5784.

**28,** MSMS/MPMLC Risk Management: Closed Claim Reviews (OB/GYN). Sep-

tember 29, WMU Regional Center, Grand Rapids, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

**29,** MSMS Caring for the Terminally III: Alternatives to Assisted Suicide, Holiday Inn, Flint, MI. Contact: Tracy Baker, MSMS Communications, (517) 336-5786.

#### October

**1-3,** MSMS "It's a Jungle Out There": Beyond Survival for Physicians, Their Partners, and Their Families. Boyne Highlands, Harbor Springs, MI. Contact: The Office of Physician Education, (517) 336-5784.

**5, 6, 7,** MSMS/MPMLC Closed Claim Reviews (OB/GYN). October 5, Treasure Island, Saginaw, MI. October 6, Novi Hilton, Novi, MI. October 7, MSMS Headquarter, East Lansing, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.



#### **MEETINGS**

- **5, 6, 7,** MSMS Providing Outstanding Patient Service. October 5, Grand Traverse Resort, Traverse City, MI. October 6, Fetzer Center, Kalamazoo, MI. October 7, Troy Marriott, Troy, MI. Contact: The Office of Physician Education, (517) 336-5784.
- **7-8,** MSMS American-Russian International Sports Medicine Symposium: "The Humanization of Medicine." Michigan Athletic Club, East Lansing, MI. Contact: The Office of Physician Education, (517) 336-5784.
- **12,** MSMS/MPMLC Practice Parameters: Cookbook Care...or the Recipe for Ensuring Quality?, Novi Hilton, Novi, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.
- 13, 18, 19, 27, MSMS/MPMLC Risk Management: Closed Claim Reviews (Ophthalmology). October 13, WMU Regional Center, Grand Rapids, MI. October 18, Treasure Island, Saginaw, MI. October 19, MSMS Headquarters, East Lansing, MI. October 27, MPMLC Metro office, Bloomfield Hills, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

- **14-15,** MSMS Medical Biller Training Series: Medicare. MSMS Headquarters, East Lansing, MI. Contact: The Office of Physician Education, (517) 336-5784.
- **15-16,** MSMS Health Effects of Great Lakes Pollution. Radisson on the Lake, Ypsilanti, MI. Contact: Mary Anne Ford, Manager, Medical Economics and Health Care Delivery, (517) 336-5721.
- **18, 19, 20, 21, 22,** MSMS Exceptional Medical Assistant. October 18, Grand Traverse Resort, Traverse City, MI. October 19, Fetzer Center, Kalamazoo, MI. October 20, Hotel Baronette, Novi, MI. October 21, Treasure Island, Saginaw MI. October 22, WMU Regional Center, Grand Rapids, MI. Contact: The Office of Physician Education, (517) 336-5784.
- **20, 21,** MSMS/MPMLC Fundamentals of Risk Management. October 20, Grand Traverse Resort, Traverse City, MI. October 21, Novi Hilton, Novi, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-13451.
- **27,** MSMS Pain and Symptom Management for the Incurably III: Alternatives to Assisted Suicide, Westin Hotel, Detroit,

MI. Contact: Tracy Baker, MSMS Communications, (517) 336-5786.

#### November

- **3, 4,** MSMS/MPMLC Risk Management; Colon and Prostate Cancer: Avoiding Two Common Malpractice Traps. November 3, WMU Regional Center, Grand Rapids, MI. November 4, Novi Hilton, Novi, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.
- **4, 5,** MSMS Medical Biller Training Series: Medicaid. Novi Hilton, Novi, MI. Contact: The Office of Physician Education, (517) 336-5784.
- **8,** MSMS/WCMS/MHA Rhoades Lectur on Family Medicine "The Team Approach to the Silence of Violence" Developing Hospital-Based Programs. Wayne County Medical Society Headquarters, Detroit, MI Contact: Judy Marr, MSMS Manager, Communications and Professional Relations, (517) 336-1351.
- **9-11,** MSMS Annual Scientific Meeting, Westin Hotel, Detroit, MI. Contact: Sarah Continued on following page



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#### MEETINGS

Continued from page 65

Cressman, MSMS Assistant for Physician Education, (517) 336-5727.

16, 17, MSMS/MPMLC Fundamentals of Risk Management. November 16, Fetzer Center, Kalamazoo, Ml. November 17, Port Huron Hospital, Port Huron, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

**18-19,** MSMS Orientation to the Medical Office. Treasure Island, Saginaw, MI. Contact: The Office of Physician Education, (517) 336-5784.

24, MSMS Pain and Symptom Management for the Incurably III: Alternatives to Assisted Suicide, Fetzer Center, Kalamazoo, Ml. Contact: Tracy Baker, MSMS Communications, 517/336-5786.

#### Michigan Specialty Society Meetings October

22-23, Michigan Sleep Disorders Association, Holiday Inn, Traverse City, MI. Contact: Edward Stepanski, 313/972-1800.

#### **AMA Meetings**

#### October

23, Physicians' Forum: Agenda for Action, San Francisco, CA. Call 800-621-8335 for details and registration informa-

#### November

5. Physicians' Forum: Agenda for Action, Dallas, TX. Call 800-621-8335 for details and registration information.

20, Physicians' Forum: Agenda for Action, Philadelphia, PA. Call 800-621-8335 for details and registration informa-

#### December

**5-8,** AMA Interim Meeting, New Orleans, LA. Contact: Judy Marr, Manager, MSMS Department of Communications & Professional Relations, 517-336-5744.

#### National Specialty **Society Meetings** October

13-17, American Society of Internal Medicine Leadership Development Conference, Portland, OR. Contact: Melinda Klein, (202) 835-2746, ext. 266.

21-22, National Association of Managed Care Physicians, Managed Care in the 90's. Contact: Laura Russell, 800-722-0376.

29-31, American Society of Bariatric Physicians, Westin Hotel, Chicago, III. Contact: (303) 779-4833.

#### November

4-7, American Pain Society 12th Annual Scientific Meeting, Buena Vista Palace, Lake Buena Vista, Orlando, FL. Contact: Cynthia Porter, (708) 966-5595.

#### Other Meetings

#### October

28-31, Society for Professional Well-Being Conference Helps Health Professionals Meet Change. Contact: Marjorie Harrison, (919) 489-9176.



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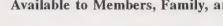
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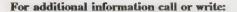
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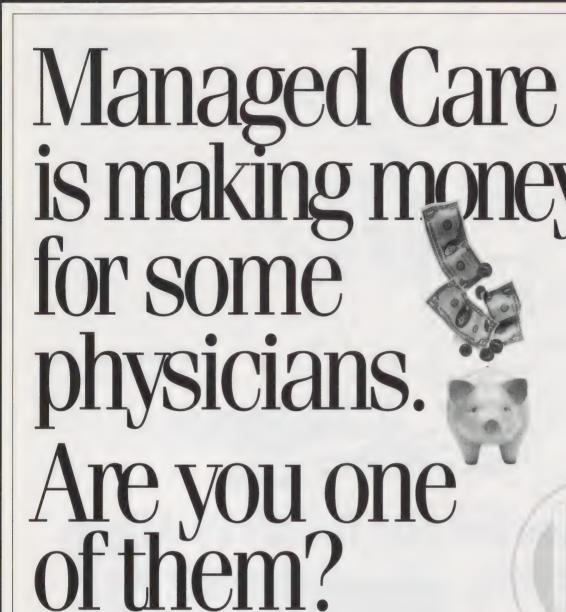
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## **CATEGORY I COURSES**

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

#### September

7, "Examining Emotional Contact: A Basic Requirement of Psychotherapeutic Interventions." Location: The Bar-Levav Educational Association, Southfield, Michigan. Sponsor: The Bar-Levav Educational Association. Contact: Joseph Gluski, MD, BarLevav Educational Association, 3000
Town Center, Suite 1275. Southfield, MI

48075, (313) 353-5333. **Approved for:** 4 hours Category I Credit.

**9-10,** Critical Clinical Issues in the Care of the Elderly: Oral Health, Dysphagia, Aspiration and Pneumonia. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan and Cleveland Regional Medical Education Center, Department of Veteran Affairs. Contact: Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. Approved for: 12 hours Category I Credit.

**9-10,** Colposcopy for the Primary Care Physician. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 12 hours

Category I Credit.

**11-12, GYN Procedures. Location:** Ashman Court Hotel, Midland Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. **Approved for:** 13 hours Category I Credit.

**15,** Diagnosis and Management of Myocardial Infarction. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** Michigan State Medical Society and Michigan Physicians Mutual Liability Company. **Contact:** Julie Smith, MSMS Chief, Risk Management, (517) 337-1351. **Approved for:** 5 hours Category I Credit.

**16,** Management of Diabetics-Mellitus in the 90's. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo, Michigan. **Sponsor:** Michigan State University, Kalamazoo Center for Medical

Continued on page 71

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#### MICHIGAN STATE MEDICAL SOCIETY



## Seminars Conferences for September 1993

| Se | nte | mbe | 21  |
|----|-----|-----|-----|
| 20 |     |     | v 2 |

Supervisory Skills Series - Part IV (Maximize Your Time, Energy and Brainpower)

September 8

Trov Marriott, Trov

September 10 \$175 for MSMS/other members, \$225 for non-members

WMU Regional Center, Grand Rapids

Risk Management: Closed Claim Reviews (Orthopedic Surgery)

September 9

WMU Regional Center, Grand Rapids

September 15

Treasure Island, Saginaw MPMLC Metro Office, Bloomfield Hills

September 23 September 28

MSMS Headquarters, East Lansing

\$55 for MSMS members and non-members

POs and PHOs: Cornerstones to Successful Health Care Reform

September 10-11 Embassy Suites, Southfield

\$225 MSMS/MAOPS/MMGMA members, \$325 non-members

Medical Biller Training Series (Blue Cross/Blue Shield)

September 13-14 MSMS Headquarters, East Lansing \$300 per two-day session for MSMS/other members, \$400 for non-members

Risk Management: Diagnosis and Management of Myocardial

Infarction

September 15

Grand Traverse Resort, Traverse City

September 22 September 23 Novi Hilton, Novi

WMU Regional Center, Grand Rapids

\$157 MSMS members, \$185 non-members

**Fundamentals of Risk Management** 

September 21

Holiday Inn. Marguette

\$65 MSMS members, \$80 non-members

Orientation to the Medical Office

September 23-24 MSMS Headquarters, East Lansing \$95 MSMS/MMGMA/MSMA members or their office staff. \$125 non-members. Earns CMA Credit and \$50 discount on another program!

Risk Management: Closed Claim Reviews (Ob/Gyn)

September 29 WMU Regional Center, Grand Rapids \$55 MSMS members and non-members

Caring for the Terminally Ill: Alternatives to Assisted Suicide

September 29 Holiday Inn, Flint

\$55 1/2 day registration fee

Location

Specialty

If you or other staff in your office would like a detailed brochure on these and upcoming MSMS programs, please call the Office of Physician Education at (517) 336-5784.

State

☐ Other

Date

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Zip

Fee

#### **CATEGORY I COURSES**

Continued from page 69

Studies. **Contact:** Charles L. Zeller, Jr., MD, MSU/KCMS, 1535 Gull Road, Suite 230, Kalamazoo, MI 49001. **Approved for:** 3.75 hours Category I Credit.

17, "Contemporary Issues in Detection, Diagnosis and Management of Child Abuse and Neglect". Location: The Ritz Carlton Hotel, Dearborn, Michigan. Sponsor: Henry Ford Hospital. Contact: Henry Ford Hospital, Office of Continuing Medical Education, (313) 876-3073. Approved for: 7 hours Category I Credit.

17-18, EGD (Gastroscopy). Location: Ashman Court Hotel, Midland Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallman, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 12 hours Category I Credit.

**18,** Endoscopy Surgery. Location: Auditorium of BC/BS, Southfield, Michigan. Sponsor: Blue Cross and Blue Shield of Michigan. Contact: Della Sansouci, Continuing Medical Education Office, BC/BS of Michigan, 27000 W.

Eleven Mile Rd., Southfield, MI 48034, Mail Code: B499, (313) 354-8500, Ext. 3827.

18, Surgical Radiography: Technologist Strategies for Excellence in the Operating Room. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Department of Radiology. Contact: Melody Curry, Registrar, Office of Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. Approved for: 8 hours Category I Credit.

**21,** Cardiovascular Research Forum. Location: Michigan Athletic Club, East Lansing, Michigan. Sponsor: American Heart Association. Contact: American Heart Association of Michigan, 16310 W. 12 Mile, P.O. Box 760160, Lathrup Village, MI 48076, (313) 557-9500. Approved for: 6 hours Category I Credit.

**20-21, Update on Pulmonary and Critical Care Medicine. Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medi-

cal School, Department of Internal Medicine. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 15 hours Category I Credit.

**22-23,** The Fifth Annual Workshop Course, Office Procedures for Primary Care Physicians. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, and the Michigan Academy of Family Physicians. **Contact:** Melody Curry, Registrar, Office of Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157. **Approved for:** 16 hours Category I Credit.

**22, 23,** Diagnosis and Management of Myocardial Infarction. Location: September 22, Novi Hilton, Novi, Michigan. September 23, WMU Regional Center, Grand Rapids, Michigan. **Sponsor:** Michigan State Medical Society Continued on following page

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#### **CATEGORY I COURSES**

Continued from page 71

and Michigan Physicians Mutual Liability Company. **Contact:** Julie Smith, MSMS Chief, Risk Management, (517) 337-1351. **Approved for:** 5 hours Category I Credit.

**29,** Effective Compassion for the Incurably III: Alternatives to Assisted Suicide. Location: Holiday Inn, Flint, Michigan. Sponsor: Michigan State Medical Society. Contact: Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48826-0950, (517) 336-5784. **Approved for:** 3.5 hours Category I Credit.

**30,** "Doctor, I Can't Sleep" - A Course on Insomnia. Location: Dearborn Inn-Marriott, Dearborn, Michigan. Sponsors: National Sleep Foundation and Henry Ford Hospital Sleep Disorders Center. Contact: Reid C. Blank, Program Director, National Sleep Foundation, 122 S. Robertson Bl, Third Floor, Los Angeles, CA 90048, (310) 288-0466. Approved for: 3 hrs AAFP credit.

**30- Oct. 2,** 15th Annual Seminar in Diagnostic Ultrasound. Location:

Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Registrar, Office of Continuing Medical Education, Towsley Center, P.O. Box 1157, University of Michigan Medical School, Ann Arbor, MI 48106-1157, (313) 936-9800. **Approved for:** 15 hours Category I Credit.

#### October

**5, 6, 7,** Providing Outstanding Patient Service. Location: October 5, Treasure Island, Saginaw, Michigan. October 6, Novi Hilton, Novi, Michigan. October 7, MSMS Headquarters, East Lansing, Michigan. Sponsor: Michigan State Medical Society. Contact: Office of Physician Education, (517) 336-5784. Approved for: 6 hours Category I Credit.

7, 8, American Russian International Sports medicine Symposium. Location: Michigan Athletic Club, East Lansing, Michigan. Sponsor: Michigan State Medical Society. Contact: Office of Physician Education, (517) 336-5784. Approved for: 12 hours Category I Credit

12, MSMS Risk Management Seminar, "Medical Practice Parameters." Location: Novi Hilton, Novi Michigan. Sponsor: Michigan State Medical Society and Michigan Physicians Mutual Liability Company. Contact: Julie Smith, MSMS Chief, Risk Management. Approved for: 3.5 hours Category I Credit.

**16,** Newest Concepts in Ophthalmic Diagnosis and Therapy. Sponsor: Franklin Eye Consultants. Location: Northfield Hilton, Troy, Michigan. Contact: Hugh Beckman, MD 29275 Northwestern Hwy, Suite 100, Southfield, MI 48034, (313) 353-1750. **Approved for:** 5.5 hours Category I Credit.

17-18, Fiberoptics Workshops for the Difficult Airway. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Department of Anesthesiology. Contact: Melody Curry, Registrar, Office of Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157. Approved For: 17 hours Category I Credit.

Continued on page 74

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INSURANCE PROGRAMS

#### **CATEGORY I COURSES**

Continued from page 72

**22-23,** Contraceptive Update/No-Scalpel Vasectomy. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 15 hours Category I Credit.

**27,** Effective Compassion for the Incurably III: Alternatives to Assisted Suicide. Location: Westin Hotel, Detroit, Michigan. Sponsor: Michigan State Medical Society. Contact: Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48826-0950, (517) 336-5784. **Approved for:** 3.5 hours Category I Credit.

**28-29,** Colonoscopy/Common Anorectal Disorders/Hemorrhoids. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 11.5 hours Category I Credit.

**29-30,** Stress EKG. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 11.5 hours Category I Credit.

#### November

**3, 4,** Diagnosis and Management of Colon & Prostate Cancer. Location: November 3, WMU Regional Center, Grand Rapids, Michigan. November 4, Novi Hilton, Novi, Michigan. **Sponsor:** Michigan State Medical Society and Michigan Physicians Mutual Liability Company. **Contact:** Julie Smith, MSMS Chief, Risk Management, (517) 337-1351. **Approved for:** 5 hours Category I Credit.

**4-5,** An Update in Neonatology: The Horizon.... and Beyond. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Department of Pediatrics. Contact: Melody Curry, Registrar,

Towsley Center for Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 13 hours Category I Credit.

**4-5,** Selected Topics in Clinical Nutrition. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School and College of Pharmacy. Contact: Melody Curry, Registrar, Office of Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. Approved for: 11 hours Category I Credit.

**5-6,** Colposcopy for the Primary Care Physician. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallman, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 12 hours Category I Credit.

**6,** LEEP. Location: Ashman Court Hotel, Midland, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Linda Allmann, 4909 Hedgewood Dr.,



## MSU ASSOCIATES

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**7, Colposcopy Update. Location:** Ashman Court Hotel, Midland, Michigan. **Sponsor:** The national Procedures Institute. **Contact:** Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. **Approved for:** 7.5 hours of Category I Credit.

**8,** MSMS Forum on Family Violence. Location: Wayne County Medical Society, Detroit, Michigan. Sponsor: Michigan State Medical Society. Contact: Office of Physician Education, (517) 336-5784. Approved for: 7 hours Category I Credit.

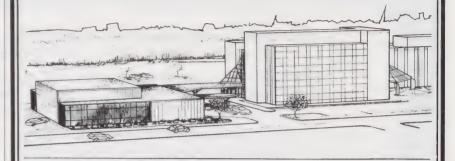
10-11, Potpourri #3. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 15 hours Category I Credit.

19-20, Sclerotherapy/Peripheral Vascular Evaluation. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 11.5 hours of Category I Credit.

23-28, Pediatric Board Review. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Michigan Association of Pediatric Program Directors, Michigan Chapter, American Academy of Pediatrics. Contact: Marie McKnight, Registrar, Towsley Center for Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 936-9800. Approved for: 60 hours Category I Credit.

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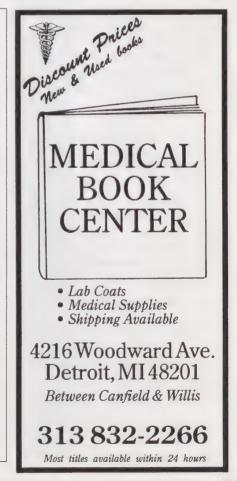
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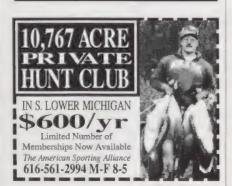
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## PRESIDENT'S PAGE

#### **Rural America and Health System Reform**

By Gilbert B. Bluhm, MD

his month is expected to mark the release of the Health System Reform (HSR) proposal by the Clinton Administration. The last three months have been filled with unofficial hints or "trial balloons" from some of Clinton's HSR "team" which includes "Hillary, Ira and Tipper" (The acronym spells the "HIT" team!). All this has resulted in health providers, business coalitions, and other "vested" public interests speculating and predicting

the Clinton Administration Plan. And incidently, it is likely to include a spending "cap" or National Global Budget. The new "HIT" team will be called the National Health Board or some *forme fruste*!

A major concern is the Congressional response to "Managed Competition," the expected *hallmark* of the HSR. The AMA currently defines "managed competition" as: "A health insurance system that would band together employers, labor groups, and others into insurance purchasing groups. Employers and other collective purchasers would make a set contribution toward purchase of insurance for individuals they represent. The set contribution acts as an incentive for insurers and providers to compete. The AMA *supports* enhanced market competition in a pluralistic health system but *opposes* plans that unfairly concentrate market power of payors or are given a competitive advantage through government policies."

What its implementation may yield after Congress finishes with it only the Almighty knows!

Rural areas in the USA have geographic barriers (such as mountains and lakes), severe winters, inadequate roads, and longer distance from health services and facilities. The rural population accounts for 27 percent of the US population. However, there is a larger and growing proportion of senior citizens in rural areas. Furthermore, one-third of US citizens below the poverty level reside in rural America. Also, there are other characteristics such as a greater percentage of unemployed, self-employed, seasonally employed or employed by small business in rural areas. Agricultural workers represent three percent of the US workforce, but account for 14 percent of all work-related deaths!



Access to health care in a rural area can be hampered by a shortage of primary care physicians. Will these areas of shortage be covered independently by a nurse or physician assistant? Will the time to reach a healthcare facility be within 30 minutes or take much longer? When emergency services are necessary will there be a nearby emergent care center easily reached by emergency medical service road vehicles or helicopters? Should superspecialty care

such as transplants and "high" technology services be in the rural area or contracted to the nearest "tertiary" health center or elsewhere, dependent upon cost and *not* ease of accessibility?

Cost "saving" is expected to be a major thrust of managed competition. Who will determine the service fee in a rural area? The fee could be established as the lowest cost of the adjacent "accountable health plans" (AHPs). Still the government (federal or state) may determine the fee for service by "price fixing," or use an RBRVS system with a conversion factor and add a rural incentive "plus" factor. The "Jackson Hole Group" which developed and pioneered managed competition, has introduced a "new costucrat" called the "Rural AHP Implementation Authorities" to select and monitor the AHPs assigned to rural areas. And the Clinton Administration promises less bureaucracy!

If there remains any good news for rural America, it is at least two-edged. Congress will "jawbone" for about another year before legislation on federal health system reform is passed. Only the Almighty knows the length of the transition period, which is projected to be three to five years.

From my travels so far in the rural areas of Michigan, the physicians and hospitals are better poised than in my urban area because of "TLC," namely, *trust, loyalty and collegiality!* Rural physicians seem to have more "communal" attitude among themselves and with their hospitals, whether the hospital has 30 or 150 beds!

Perhaps it's time for physicians to recall the comment of William Allen White on his 70th Birthday. "I am not afraid of tomorrow for I have seen yesterday, and I love today."

Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. Clin Cardiol. 1991;14:146-151.

#### PRAVACHOL® (Pravastatin Sodium Tablets)

EONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atheroscierosis is a chronic process and discontinuation of lipid-lowening drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

patient apprised of the potential nazard to the letus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients of the property of the prop whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in

rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin.

Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal persists, then therapy should be discontinuad. Persistence of significant aminotransferase elevations following discontinua-

then therapy should be discontinued. Persistence of signiticant aminotransferase elevations rollowing discontinua-tion of therapy may warrant consideration of liver biopsy. Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS), Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phospholianase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tendemess or weakness, and/or markets elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tendemess or weakness, particularly if accompanied by malaise or fever. Pravastatin therapy should be discontinued if markets and control of CPK and the second of the court of the property in the court of the cou

sess, particularly if accompanied by malaise or lever. Pravastatin therapy should be discontinued if markedly elevated CFK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyofysis, e.g., sepsis; hypotension; major surgery; traumar; severe metabolic, endocrine, or electrohyte disorders; or uncontrolled epilepsy.

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gentrollycoller, experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gerniforozil showed a trend toward more frequent CFK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gerniforozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PEECAUTIONS: Drug Interactions). One patient developed myopathy when cloftorate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when cloftorate therapy was stopped and pravastatin realment continued. The use of fibrates about generally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.

of pravastatin and fibrates should generally be avoided.

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin. Homozygous Familial Hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3a-hydroxy isomeric metabolite (SQ 31,966). A small increase was seen in mean AUC values and half-life (t/2) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tendemess or

pravastatin should be closely monitored.

Information for Patients: Patients: Adulto be advised to report promptly unexplained muscle pain, tendemess or weakness, particularly if accompanied by malaise or fever.

Prug Interactions: Immunosuppressive Drugs, Gemifibrozil, Niacin (Nicotinic Acid), Erythromycin: See WARN-INSS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin in sea administered 1 hour before or 4 hours after choles-tyramine or 1 hour before colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin mass administered 1 hour before or 4 hours after choles-tyramine or 1 hour before colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin made, there was no clinically significant decrease in bio-availability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy).

Warfarn: In a study involving 10 healthy male subjects given pravastatin and varianic concomitant ty of 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not after the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Craw of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme protongation of prothrombin time after 6 days of concomitant the

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers,

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Besulfs clinical trials with pravastatin in males and post-menopausal fernales were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadorippin was significantly reduced (p<0.004) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the priturlary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating

infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose this produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vest bibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose (p<0.01). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels approximately 0.5 to 5.0 times human drug levels approximately of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels approximately 0.5 to 5.0 times human drug levels approximately or 10, and 10 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels approximately 0.5 to 6.0 times higher than the mean human serum drug co

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular trophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

fety in pregnant women has not been established. Prayastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at dosso of up to 50 mg/kg daily. These dosso resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter<sup>2</sup>). However, in studies with another HMG-CoA reducta administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the poten-

erious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see

tial for serious adverse reasonable.

CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: General.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overal incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% or pravastatin-treated patients in the placebo-controlled trials are identified in the table below, also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

|                     | All Events %             |                      | Events Attributed to Study Drug % |                      |
|---------------------|--------------------------|----------------------|-----------------------------------|----------------------|
| Body System/Event   | Pravastatin<br>(N = 900) | Placebo<br>(N = 411) | Pravastatin<br>(N = 900)          | Placebo<br>(N = 411) |
| Cardiovascular      |                          |                      |                                   |                      |
| Cardiac Chest Pain  | 4.0                      | 3.4                  | 0.1                               | 0.0                  |
| Dermatologic        |                          |                      |                                   |                      |
| Rash                | 4.0*                     | 1.1                  | 1.3                               | 0.9                  |
| Gastrointestinal    |                          |                      |                                   |                      |
| Nausea/Vomiting     | 7.3                      | 7.1                  | 2.9                               | 3.4                  |
| Diarrhea            | 6.2                      | 5.6                  | 2.0                               | 1.9                  |
| Abdominal Pain      | 5.4                      | 6.9                  | 2.0                               | 3.9                  |
| Constipation        | 4.0                      | 7.1                  | 2.4                               | 5.1                  |
| Flatulence          | 3.3                      | 3.6                  | 2.7                               | 3.4                  |
| Heartburn           | 2.9                      | 1.9                  | 2.0                               | 0.7                  |
| General             |                          |                      |                                   |                      |
| Fatigue             | 3.8                      | 3.4                  | 1.9                               | 1.0                  |
| Chest Pain          | 3.7                      | 1.9                  | 0.3                               | 0.2                  |
| Influenza           | 2.4°                     | 0.7                  | 0.0                               | 0.0                  |
| Musculoskeletal     |                          |                      |                                   |                      |
| Localized Pain      | 10.0                     | 9.0                  | 1.4                               | 1.5                  |
| Myalgia             | 2.7                      | 1.0                  | 0.6                               | 0.0                  |
| Nervous System      |                          |                      |                                   |                      |
| Headache            | 6.2                      | 3.9                  | 1.7*                              | 0.2                  |
| Dizziness           | 3.3                      | 3.2                  | 1.0                               | 0.5                  |
| Renal/Genitourinary |                          |                      |                                   |                      |
| Urinary Abnormality | 2.4                      | 2.9                  | 0.7                               | 1.2                  |
| Respiratory         |                          |                      |                                   |                      |
| Common Cold         | 7.0                      | 6.3                  | 0.0                               | 0.0                  |
| Rhinitis            | 4.0                      | 4.1                  | 0.1                               | 0.0                  |
| Cough               | 2.6                      | 1.7                  | 0.1                               | 0.0                  |

statistically significantly different from placebo.
The following effects have been reported with drugs in this class:

The following effects have been reported with drugs in this class: Skeletal: myopathy, rhabdomyolysis. Neurological: dystunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy. Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, lever, chilis, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome. Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting. Reproductive: gynecomastia, loss of libido, erectile dysfunction. Eye: progression of cataracts (lens opacities), ophthalmoplegia. Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).
Transient, asymptomatic essinophilia has been reported. Eosinophili counts usually returned to normal despite continued therapy. Anema, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Iransent, asymptomatic ecsnophila rise been reported. Ecsnophil counts usually returned to normal despite contrud therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reduction enhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nico-trici acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is not associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (the rive without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with homeoperspind of the properties of the complexity in the properties of the complexity individual their complexity in the properties. immunosuppressive drugs, gerifibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNIMGS: Skeletal Muscle and PRECAUTIONS: Drug Interactions.)

#### DVERDOSAGE

ere have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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Active liver disease or unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of prayastatin sodium

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.



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## EDICINE



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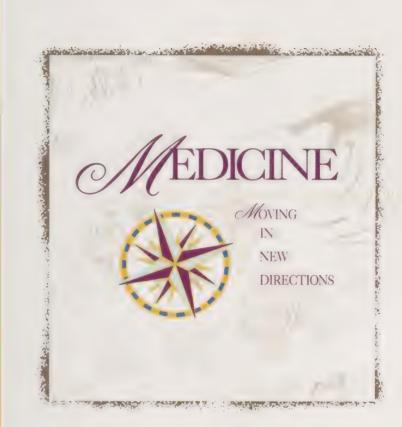


#### **MSMS Annual Scientific Meeting Final Program Issue**

- included are: • Capsule Schedule
- Special Events
- Course Schedule
- Exhibitor Info
- Registration Form

#### Also included in this issue:

- Legal Briefs
- In Memoriam: Richard Rapport, MD
- Membership Report from MSMS Alliance
- In Focus: The Burton Free Clinic





Michigan State Medical Society

1993 ANNUAL SCIENTIFIC MEETING

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### MICHIGAN MEDICINE

OCTOBER 1993 VOLUME 92, NO. 10

Award-Winning Journal of the Michigan State Medical Society

#### SPECIAL ISSUE

This month's *Michigan Medicine* serves as the official final program issue for the MSMS Annual Scientific Meeting slated for November 9-11 at Detroit's Westin Hotel. The meeting will offer more than 50 courses on timely medical topics which cut across all specialties. "Moving in New Directions," this year's Annual Scientific Meeting is certain to be better than ever. A capsule schedule, special events, a course schedule, exhibitor information and more are included in this final program issue.



#### **OTHER KEY ARTICLES**

#### 14

#### MPMLC Offers Insurance to Minnesota Physicians

Michigan Physicians Mutual Liability Company fulfills need for worker's compensation insurance in Minnesota.

By Thomas R. Berglund, MD

#### 16

#### In Memoriam: Richard Rapport, MD

A salute to a man who "truly was a doctor's doctor." By Carl A. Gagliardi, MD

#### 49

#### MSMS Alliance Targets Today for Tomorrow

A report from Alliance Vice President and Membership Chair Jean Howard.

#### 51

#### In Focus: Burton Free Clinic

The Burton Free Clinic is a point of light for Flint's indigent. This feature spotlights the clinic and its founder, Marigowda Nagaraju, MD.

By Helen Fordham

#### **DEPARTMENTS**

- 9 MSMS ON THE MOVE
- 11 LEGAL BRIEFS
- **55 NEW MEMBERS**
- 65 MEETINGS
- **69 CATEGORY I COURSES**
- **76 CLASSIFIEDS**
- 79 ADVERTISING INDEX
- **80 PRESIDENT'S PAGE**

#### In next month's issue:

Report on MSMS Membership Activities and Services

Cover illustration: Hudson Creative Group

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gan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

David H. Gilbert. MD

Laurium

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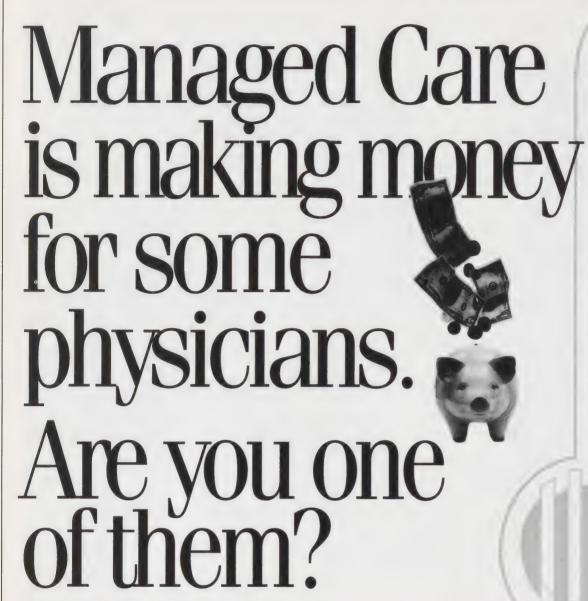
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# **MSMS**

### VIS ON THE MOVE

### MSMS develops communications plan for health system reform proposal



As the anticipated release of the Clinton health system reform plan neared, MSMS prepared to use a variety of communications avenues to quickly inform MSMS leaders and membership about the proposal. Target audiences also are patients and state and US legislators.

#### Goals

Quick, accurate and detailed information to MSMS leaders and membership will allow for rational, well-informed discussion and dialogue among colleagues, with patients and with the media. Relaying and repeating the goals of organized medicine to all publics throughout the reform process will be critical to affecting any final decisions made by Congress.

#### Strategies and tactics

The strategy will be to use every communications vehicle available to MSMS to disseminate information quickly, including fax packets to MSMS leaders, *Medigram*, *Michigan Medicine*, statewide leadership meetings, statewide grassroots meetings, news releases, editorial board visits, radio and TV talk shows, letters to the editor and guest columns in newspapers statewide, national AMA meetings, the 10 Questions bookmarks and posters, AMA publications including the four-page brochure answering the 10 Questions and the follow-up tri-fold brochure answering the earlier 20 questions. Extra copies of the AMA's December 1 issue of its 32-page *Business and Health* magazine also will be obtained for use in Michigan.

Initial information will be obtained from the AMA Electronic Network. The AMA promises to have an AMA analysis of the Clinton proposal on the Network within 24 hours after the proposal is announced.

#### Timetable October

- Present AMA and MSMS printed pieces to legislators, business leaders, et al.
- Consider sending MSMS president to AMA meeting on Clinton reform proposal.
- Develop and send "county columns" on health system reform.
- Develop and send newspaper "op-ed" pieces and letters to the editor on health system reform.
- Develop and send short pieces to specialty society bulletins.
- Seek radio and TV talk show appearances.
- Continue editorial board visits.
- 13th, MSMS host informal briefing for various MSMS leaders.
- Develop MSMS/AMA information into slide show presentation for leadership to present at county society meetings; inform county society presidents and executives about availability.

#### November

- 10th-Specialty Society Presidents' luncheon during ASM devoted to health reform.
- 20th-AMA "Physician's Forum: Agenda for Action" in Philadelphia.
- Continue health reform standing sidebar in *Medigram*

#### December

- December issue of *Michigan Medicine* devoted to health system reform.
- Continue health reform standing sidebar in *Medigram*.
- Continue news releases, columns, letters, as needed.

#### January

- Continue health reform standing sidebar in *Medigram*.
- Continue news releases, column, letters, as needed.

#### **February**

■ Begin *Michigan Medicine* cover stories on aspects of reform.

For more information on the MSMS Communications plan, contact Judy Marr or Dave Fox at MSMS 517/337-1351.

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By Richard D. Weber MSMS Legal Counsel

### Corporate Practice of Medicine

rguments on the application of the corporate practice of medicine doctrine in Michigan have heated up. The following summarizes recent activities that have fueled the debate, discusses the most recent opinion of the Attorney General regarding nonprofit corporations and provides some commentary on the legal and policy issues.

The corporate practice of medicine doctrine prohibits corporations from employing physicians to provide medical services. Although the doctrine has been around for decades, it has only recently become a major issue in Michigan. In 1989 the Attorney General rendered an opinion that a domestic corporation formed under the Business Corporation Act ("BCA") may not engage in activities which may only be performed by one of the learned professions. The Attorney General further opined that the Corporation and Securities Bureau of the Department of Commerce ("Bureau") should not accept document filings from such corporations performing professional services and further opined that such corporations should comply with the Professional Services Corporation Act ("PC Act"). The Bureau then determined that there was no distinction between profit and nonprofit corporations in the rationale set forth in the Attorney General's opinion and, therefore, applied the opinion to corporations formed under both the BCA and the Nonprofit Corporation Act ("NCA"). To accommodate the concerns expressed by hospitals, the Bureau issued a release in August, 1992, advising that it would begin to accept articles of incorporation for nonprofit hospital corporations so long as the articles contained a clear disclaimer of any intent to engage in the practice of medicine. This release generated additional pressure from interest groups and led to a change of position by the Bureau in January, 1993. The Bureau rescinded its prohibition against the filing of documents which contain language manifesting a purpose to practice medicine, but concluded that "this determination does not mean that the Bureau believes that the learned profession doctrine does not apply to the practice of medicine by nonprofit corporations."

The MSMS House of Delegates earlier this year adopted a resolution supporting the corporate practice of medicine doctrine. By this action MSMS established policy against corporations, both profit and nonprofit, employing physicians to deliver medical services to the public.

Because of the uncertainty regarding the application of the doctrine to nonprofit corporations, the following question was propounded to the Attorney General:

"May a corporation incorporated under the Michigan Nonprofit Corporation Act provide medical care services as defined in MCL 333.17001(1)(a) and (c) to the public through employed physicians; or is the practice of medi-

cine through a corporate structure limited to corporations incorporated under the Professional Services Corporation Act?"

In Opinion No. 6770, issued on September 17, 1993, the Attorney General concluded that nonprofit corporations (including hospitals) may provide medical services through employed physicians. Although noting that Michigan's appellate courts have not addressed the question of whether the doctrine applies to nonprofit corporations, the Attorney General reasoned that virtually all states addressing this issue have concluded that it does not apply to nonprofit corporations because the primary public policy concerns underlying the doctrine (commercialization, lay control and limited liability of corporations) are sufficiently addressed by formation as nonprofit corporations.

The Attorney General stated that under the N.C.A. there are three reguirements for the formation of a nonprofit corporation: (1) the corporation is not required to incorporate under another statute; (2) the purposes of the corporation must be lawful; and (3) the corporation is not organized for pecuniary gain or profit of its officers, directors, shareholders or members. The Attorney General then concluded that the first and third requirements did not preclude nonprofit corporations from providing medical services through employed physicians. Under the second requirement, the Attorney General addressed the corporate practice of medicine doctrine and concluded that it did not apply to nonprofit corporations. The Attorney General reasoned that because nonprofits lack a profit-making motivation, the policy concerns giving

Continued on following page

#### **LEGAL BRIEFS**

Continued from page 11

rise to the doctrine are not applicable. The Attorney General relied primarily on cases from California for the proposition that nonprofit corporations are not subject to the doctrine in that state. The factual contexts in those decisions are unique to each case and the reliance on the statements by the Attorney General that California authorizes the corporate practice by nonprofit corporations is based essentially upon dicta.

#### Profit vs. non-profit

The law in Michigan is clear that profit corporations may not employ physicians to provide medical services to the public. The law in Michigan is equally unclear with respect to nonprofit corporations. It can be argued that the legislature intended that all learned professions wishing to conduct business in a corporate structure must do so under the PC Act. The PC Act provides many safeguards, such as the requirement that limits stockholders, members, and directors to licensed professionals. It can also be argued that the law historically precludes operating any business in a corporate structure without express statutory authority, and that no statute authorizes the practice of medicine in a corporate structure, with the exception of the PC Act and the new Limited Liability Company Act which creates a structure with both corporate and partnership characteristics. Opponents raise contrary arguments. Since there is no clear law precluding nonprofit corporations from practicing medicine through employed physicians, they argue that it should be legal. They further argue that there is no sound public policy precluding nonprofit hospitals from employing physicians to deliver medical services to the public, and any law in opposition would run contrary to existing practice and emerging trends in health care.

#### Physician control key

The fundamental basis for precluding the corporate practice of medicine is to assure that physicians control the delivery of medical care to their patients. A corporation providing medical care to the public and controlled by lay persons presents an inherent risk of lay control over the practice of medicine. There is greater control in the employment relationship than in the independent contractor relationship. If a corporate employer bills for a physician's services and retains the fees, paying the employed physician a salary, the physician may lack total independence in treating the patient which is essential to the physician-patient relationship.

Nonprofit corporations are not necessarily philanthropic institutions motivated by charity and exempt from taxation. They are not necessarily major hospitals. To allow any and all nonprofit corporations to practice medicine through employed physicians would open up the practice to all kinds of nonprofit corporate structures, such as nursing homes, professional organizations and street corner clinics. The kinds of nonprofit corporate organizations practicing medicine would be limited only by the creativity of the controlling owners or organizers. Simply because nonprofit corporations do not pay dividends, does not mean that they do not pay large executive salaries and other perquisites.

Hospitals argue that many physicians are currently practicing as employees and the system is working. Some physicians also support the employment concept. The employment relationship may work in certain situations. The question is whether physician employment should be opened up to all entities in all circumstances. Does the fact that physician employment relationships are working in some circumstances justify authorizing employed physicians in all corporate circumstances? There are viable alternatives to existing employment structures. Hospitals may contract with individual physicians, physician partnerships, professional services corporations or limited liability companies as independent contractors. Most individual and group practices throughout the state provide medical services in hospitals through medical staff privileges or more fully integrated contracts. The delivery of medical services to the public through these independent contractor structures reduces lay control concerns inherent in the employment relationship and protects professional independence which is essential in the physician-patient relationship.

#### Many options open

The Attorney General's opinion reiterates the application of the corporate practice of medicine doctrine to profit corporations but rejects its application to nonprofit corporations. Although this opinion is significant, it does not constitute the final resolution of the matter. Many options are open, including a legislative option that could focus upon authorization to certain licensed facilities to employ physicians with commensurate legislative protections against lay control over the practice of medicine and the commercialization of the profession. In the final analysis, the ultimate decision on this policy issue resides with the legislature. mm

#### MSMS reviews corporate practice of medicine

The MSMS Board of Directors on Sept. 22 discussed at length implications of and responses to Michigan Attorney General Frank Kelley's Sept. 17 opinion on the corporate practice of medicine.

The Board charged its Corporate Practice of Medicine Task Force with developing appropriate information and recommendations on:

- Groups to be addressed in future MSMS activities related to the corporate practice of medicine.
- Concerns affecting physicians employed by nonprofit corporations, and solutions MSMS can seek through legislation or negotiation with hospitals and other groups.
- Contractual, administrative and patient care protections physicians should seek in contracts with hospitals and others who might seek to employ physicians.
- MSMS activity related to the corporate practice of medicine which should be incorporated into MSMS efforts to help physicians organize for changes in the health care delivery system.

Your Banker and Accountant Won't tell you how to do this...

# Local Surgeon Discovers Amazingly Simple Secret of Taking Thousands More Out Of His Practice Without Taking A Bigger Caseload!

Southfield, MI-Dr. Allen was very tired. Tired from all the hours he puts in the office and in the hospital. And tired of seeing his money fly out the door as fast as it came in. As he was driving home from an emergency late last night, he was thinking to himself, "Boy, everyone thinks we lead such glamorous lives, full of money and excitement. I wish they could see me driving at 3am, in this rainstorm. Or if they could see the monthly overhead and cash flow I shell out. Some glamour!"

He started thinking about all the salaries and malpractice premiums, and supplies and equipment, and so on. And how he was spending thousands each month on loans and leases, and well what's the use? "It's never going to change. I need that new table, and I've got to repair that stuff in room 3, and that's going to cost me even more. Ah, forget it."

He had resigned himself to just being constantly under financial stress. His accountant and banker were friendly, but never seemed to have the answers he was looking for. He didn't think they weren't trying, but they just didn't have the creativity he really needed. He wasn't sure what he needed, but more money would sure be nice.

When he got home, he was too keyed up to sleep, and saw an article in one of his journals that offered a report on how physicians and surgeons can increase their income without increasing their caseload. He was intrigued by the information and called to get the report.

When he got the report a couple of days later, he was shocked. Shocked about how much money he could have been putting in his pocket all these years, and had flushed down the old drain. Shocked that the techniques revealed in the report were not explained to him by his advisors. Most of all, he was excited to start using the information he learned like:

- How To Uncover A Hidden Mountain Of Cash In Your Practice!
- Six Ways To Lower Your Monthly Payments By Hundreds Or Even Thousands Of Dollars!
- How To Get The Equipment You Need Without Laying Out Giant Amounts Of Money!
- How To Increase The Income From Your Practice Without Increasing Your Caseload And Stress!

And more. Dr. Allen felt the stress of his financial condition melting away, after learning what no one else had ever bothered to tell him. If you'd like to learn what he did, you can get a copy of this FREE report called, "How To Increase Your Income Without Increasing Your work, And Uncover The Hidden Cash In Your Practice!" By calling 1-800-930-9042, for a free recorded message, 24 hours a day. CALL NOW to learn what your advisors won't tell you, because they don't know!



# MPMLC expands horizons to fill void in Minnesota

By Thomas R. Berglund, MD

eminiscent of our beginnings, Michigan Physicians Mutual Liability Company (MPMLC) recently stepped in when a void developed in the Minnesota market and has begun offering workers compensation insurance there.

This move coincides with our on-going plan to bolster our long-term viability – one of the major challenges of the '90s. It will promote long-term growth, financial strength – and most importantly – policyholder security.

Minnesota's State Fund Mutual Insurance Company was forced to suspend writing new business last year. The Minnesota Insurance Agents Association, acting in a similar fashion to the Michigan State Medical Society back in 1975, sought to fill the void. Our company filled that void.

The line of insurance will be sold by members of the Minnesota Insurance Agents Association. Estimates of the first-year written premium range up to \$10 million dollars.

MPMLC's ability to remain competitive depends on financial resources – premium volume, loss reserves (to pay future claims) and surplus (savings).

The new workers comp business will allow us to build surplus faster to secure the capacity to offer reliable protection to policyholders and to offer new programs and services.

Our experience in medical liability insurance will help us. Like medical liability insurance, workers comp coverage is

# Public Relations counselors specializing in health care issue management.

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119 Pere Marquette Suite 3A Lansing, MI 48912 (517) 487-9320 This move coincides
with our on-going plan
to bolster our long-term viability -one of the major challenges
of the '90s. It will promote
long-term growth,
financial strength -and most importantly -policyholder security.

health-related. Workers comp coverage also is experiencing upward trends in claims costs. It must be closely managed to control costs.

In another move, MPMLC has expanded its liability coverage to include Michigan hospitals, clinics, and dentists. As physicians become more closely involved with new health service organizations, we anticipate this will result in new benefits, programs, and services for them.

The new lines of liability insurance will allow us to further expand in an area in which we already have expertise and a track record of success. This will strengthen and help maintain our leadership position in representing and serving the needs and interests of our policyholders – today and in the future.

The ultimate aim is to increase our policyholders' security. With additional funding sources for surplus, policyholders will have even greater assurance of our ability to protect their interests. That's important when your assets and your professional credibility are on the line.

Doctor Berglund, an MSMS Board member, is president and chair of the Board of Michigan Physicians Mutual Liability Company.

#### ATTENTION PHYSICIANS:

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CompHealth/Kron, the nation's premier locum tenens (temporary physician staffing) organization, has established a local staffing network in Michigan.

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It's a great way to make sure your patients have convenient access to quality care in *your* practice or facility.

Call us today to discuss your practice coverage needs, or to find out more about building a flexible, rewarding practice as a locum tenens physician with our Michigan staffing team!

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### IN MEMORIAM

### Richard Rapport, MD April 10, 1915 - July 22, 1993

"He truly was a doctor's doctor"

By Carl A. Gagliardi, MD, FAAP



Doctor Rapport, left, received a certificate of appreciation from outgoing MSMS President Thomas C. Payne, MD, at the 1993 MSMS House of Delegates meeting, held last spring in Dearborn.

ichard Rapport, MD, was a very good friend of mine, and I was honored that he considered me his good friend as well.

We first met early in my career at a meeting of

We first met early in my career at a meeting of the Michigan State Medical Society House of Delegates. I remember the encounter very clearly because we voiced opposite views on the issue of mandatory unified membership in county, state and national medical societies. Dick felt very strongly on the pro side, and I felt compelled to express my opposite, conservative view that no one should be forced into belonging to any organization. It took a while, but in time I, too, recognized the importance of unified membership and joined Dick in his belief that all physicians should band together at all levels so that we could more effectively accomplish what we believe to be in the best interest of our patients.

The longer I knew Dick, the greater became my admiration and respect for this multi-faceted individual. His wife, Dorrie, calls him unique, and I must agree with her. He loved Medicine, and those who were knowledgeable about him in the operating room said he was a great thoracic surgeon. Despite physical problems, he remained active until the very end as medical director of the Emergency Medical Center of Flint.

He was very bright, articulate, and above all, had something important to say. In addition to serving Medicine as a member of the MSMS House of Delegates, he was active in Genesee County Medical Society affairs, was elected for three terms to the MSMS Board of Directors and for several years was a delegate to the AMA House of Delegates. He especially enjoyed his time on the Board of Directors of Blue Cross/Blue Shield. He represented practicing physicians and felt that he helped the Board understand us better. He truly was a doctor's doctor, and I'm sure the BCBS Board knew that.

Nothing pleased Dick more than to perform on center stage and entertain us all. He sang and played the piano, often his own compositions, which were sometimes serious, but more often satirical.

Dick, at times, seemed gruff, but this was merely an exterior facade. We who knew him well saw him as a thoughtful person who really cared and desperately wanted other physicians to demonstrate their concern, their caring and their love for their patients and all mankind.

My wife and I returned to Michigan in May of this year to attend the annual meeting of the House of Delegates. We had dinner one evening with Dick and Dorrie, and what a wonderful evening it was. Despite his obvious physical distress, he was funny, mentally stimulating and a joy to be with. Marj and I consider ourselves fortunate to have known him and we shall miss him. May God bless you, friend.

Doctor Gagliardi, now retired and living in Maryland, served as chair of the MSMS Board of Directors in 1985 and as MSMS president in 1987.

Discover The Elegance Of A Hybrid



At first glance, it's the beauty of a rose that catches the eye. The vibrant color. The delicately shaped petals. But study it more closely, and its elegance becomes apparent a gentle blend of softness and strength.

At first glance, it's the enhanced performance of Vaseretic that catches the eye. But study Vaseretic more closely, and its elegance becomes apparent. The way its one-tablet, once-a-day dosage minimizes multiple

medications. Minimizes insurance copayments. And minimizes potassium supplementation.

A hybrid blending of tolerability and power that's available for the right patient. Vaseretic is indicated for the treatment of hypertension in patients for whom combination therapy is appropriate.

And an elegant discovery for your practice.

USE IN PREGNANCY: When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, Vaseretic® (Enalapril Maleate-Hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, Fetal/Neonatal Morbidity and Marketing. and Mortality

nalapril Maleate-Hydrochlorothiazide



Dosage must be individualized; the fixed combination is not for initial therapy.

Evaluation of the hypertensive patient should always include assessment of renal function.

For a Brief Summary of Prescribing Information, see adjacent pages.

#### TABLETS VASERETIC° (ENALAPRIL MALEATE-HYDROCHLOROTHIAZIDE)

USE IN PREGNANCY: When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC (Enalapril Maleate-Hydrochiorthiazide) should be discontinued as soon as possible. See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

(Enalaptii Maleater-Hydrochiorothalzide) should be discontinued as soon as possible. See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

CONTRAINDICATIONS: VASERETIC is contraindicated in patients who are hypersensitive to any component of this product and in patients with a history of angioedema related to previous treatment with an angiotensin converting enzyme inhibitor. Because of the hydrochlorothiazide component, this product is contraindicated in patients with anuria or hypersensitivity to other sulfonamide-derived drugs.

WARNINGS: Ceneral; Enalaprii Maleate; Hypotension: Excessive hypotensions was rarely seen in uncomplicated hypertensive patients but is a possible consequence of enalapril use in severely salt/volume depleted persons such as those treated vigorously with diuretics or patients on dialysis.

Syncope has been reported in 1.3 percent of patients receiving VASERETIC. In patients receiving enalapril alone, the incidence of syncope is 0.5 percent. The overall incidence of syncope may be reduced by proper titration of the individual components. (See PRECAUTIONS, Drug Interactions, and ADVERSE REACTIONS).

In patients with severe congestive heart failure, with or without associated enal insufficiency, excessive hypotension has been observed and may be associated with ofiguria and/or progressive azotemia, and rarely with acute renal failure and/or death. Because of the potential fall in blood pressure cultiment and whenever the dose of enalapril and/or threft two weeks of treatment and whenever the dose of enalapril and/or duretic is increased. Similar considerations may apply to patients with schemic heart or cerebrovascular disease, in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular saccident.

If hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses, which usually can be given w

after volume expansion

after volume expansion.

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis and/or larynx has been reported in patients treated with angiotensin converting enzyme inhibitors, including enalapril. In such cases VASERFIC should be a converting enzyme inhibitors, including enalapril. ing enzyme inhibitors, including enalapril. In such cases VÄSERETIC should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with larringeal edema may be falal. Where there is involvement of the tongue, glottor larrynx, likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL) and/or measures necessary to ensure a patent airway, should be promptly provided. (See ADVERSE REACTIONS.)

Patients with a history of angioedema unrelated to ACE inhibitor therapy

Patients with a history of angioedema unrelated to ACE inhibitor therapy may be at increased risk of angioedema while receiving an ACE inhibitor (see also CONTRAINDICATIONS).

lindy be at increased risk of alignecettian wine televiting an ACE titulitotic (see also CONTRAINDICATIONS).

Neutropenial Agranulocytosis: Another angiotensin converting enzyme inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Feriodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered. Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

function

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erystrophysics before exercised to the progression of the progres

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Lithium generally should not be given with thiazides (see PRECAU-TIONS, Drug Interactions, Englapril Maleate and Hydrochlorothiazide; Pregnancy, Enalapril-Hydrochlorothiazide; Pregnancy, Enalapril-Hydrochlorothiazide; Prese was no teratogenicity in rats given up to 90 mg/kg/day of enalapril (150 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide; 2½ times the maximum human dose) or in mice given up to 30 mg/kg/day of enalapril (50 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide; 2½ times the maximum human dose) At these doses, letotoxicity expressed as a decrease in average fetal weight occurred in both species. No fetotoxicity occurred at lower doses; 30/10 mg/kg/day of enalapril-hydrochlorothiazide in rats and 10/10 mg/kg/day of enalapril-hydrochlorothiazide in rats and 10/10 mg/kg/day of enalapril-hydrochlorothiazide in mice.

When used in pregnancy during the second and third trimesters, ACE

of enalapril-hydrochlorothiazide in mice.

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC should be discontinued as soon as possible. (See Enalapril Maleta: Fetal/Neonatal Morbidity and Mortality. ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

The use of ACE inhibitors during the second and third trimesters of pregnate problems of the problems

10 mg mg

alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic envi-

If oligohydramnios is observed, VASERETIC should be discontin unless it is considered lifeaving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after

should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as means of reversing hypotension and/or substituting for disordered renal function. Enalapril, which crosses the placenta, has been removed from neonatal circulation by peritoneal dialysis with some clinical benefit, and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure. the latter procedure

No teratogenic effects of enalapril were seen in studies of pregnant rats, and rabbits. On a mg/kg basis, the doses used were up to 333 times (in rats), and 50 times (in rabbits) the maximum recommended human dose.

and 30 times (in rabbits) the maximum recommended human dose. Hydinchlorohizade: Tentogenic Effects: Reproduction studies in the rabbit, the mouse and the rat at doses up to 100 mg/kg/day (30 times the human dose) showed no evidence of external abnormalities of the fetus due to hydrochlorothiazide. Hydrochlorothiazide given in a two-litter study in rats at doses of 4 · 5.6 mg/kg/day (approximately 1 · 2 times the usual daily human dose) did not impair fertility or produce birth abnormalities in the offspring. Thiazides cross the placental barrier and appear in cord blood. Nontreatogenic Effects: These may include fetal or neonatal jaundice, throm-bocytopenia, and possibly other adverse reactions which have occurred in the adult.

PRECALITIONS: General Englanril Malegate: Impraired Renal Function: As a con-PRECAUTIONS: cinematic inhapini vaneare; impaired kental Function: As a consequence of inhibiting the remin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe congestive heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with angiotensin converting enzyme inhibitors, including enalapril, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and /or death

failure and/or death. In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20 percent of patients. These increases were almost always reversible upon discontinuation of enalapril and/or disretic therapy. In such patients renal function should be monitored during the first few weeks of

patients retail interest seasons are the ready. Some patients with hypertension or heart failure with no apparent pre-existing renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when enalapril has been given concomitantly with a diureit. This is more likely to occur in patients with pre-existing renal impairment. Dosage reduction of enalapril and/or discontinuation of the diureite may be required.

Evaluation of the hypertensive patient should always include assess

Evaluation of the hypertensive patient should always include assessment of renal function.

Hemodialysis Patients: Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes (e.g., AN 69°) and treated commitantly with an ACE inhibitor. In these patients consideration should be given to using a different type of dialysis membrane or a different class of

ntihypertensive agent.

Hyperkalemia: Elevated serum potassium (greater than 5.7 mEq/L) was anthrypertensive agent. Hyperkalemize: Elevated serum potassium (greater than 5.7 mEq/L) was observed in approximately one percent of hypertensive patients in clinical trials treated with enalapril alone. In most cases these were isolated values which resolved despite continued therapy, although hyperkalemia was a cause of discontinuation of therapy in 0.28 percent of hyperkalemia was a cause of discontinuation of therapy in 0.28 percent of hyperkalemia was less frequent (approximately 0.1 percent) in patients treated with enalapril plus hydrochlorothiazide. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements and/or potassium-tontaining salt substitutes, which should be used cautiously, if at all, with enalapril, (See Drug Interactions.)

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgeny/Aussthesia: In patients undergoing major surgery or during aneshesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion. 
Hydrochlorothiacide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Warning signs or symptoms of fluid and electrolyte imbalance, irrespective of cause, include dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, confusion, seizures, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and voroiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhois is present, or after prolonged therapy. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia may cause cardica arrhythmia and may also sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Because enalapril reduces the production of aldosterone, concomitant therapy with enalapril attenuates the diuretic-induced potassium loss (see Drug Interactions, Agents Increasing Serum Potassium).

Although any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease), chloride replacement may be required in the

treatment of metabolic alkalo

Dilutional hyponatremia may occur in edematous patients in hot weat appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatrema is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain

Hyperuncema may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

In diabetic patients dosage adjustments of insulin or oral hypoglycemic agents may be required. Hyperglycemia may occur with thiazide diureits. Thus latent diabetes mellitus may become manifest during thiazide therapy.

The antihypertensive effects of the drug may be enhanced in the postsym-

pathectomy patient

pathectomy patient.

If progressive renal impairment becomes evident consider withholding or discontinuing diuretic therapy.

This grazides have been shown to increase the urinary excretion of magnesium; this may result in hypomagnesemia.

This grazides may decrease urinary calcium excretion. This grazides may cause intermitent and slight elevation of serum calcium in the absence of known disorders of calcium metabolism. Marked hypercalcemia may be evidence of hidden hyperparathyroidism. This grazides should be discontinued before carrying out tests for parathyroid function.

Increases in cholesterol and triglyceride levels may be associated with this grazide diureit (herapy.

Increases in cholesterol and triglyceride levels may be associated with thiaacide diuretic therapy. 
Information for Patients; Angioedema: Angioedema, including laryngeal edema, 
may occur especially following the first does of enalapril. Patients should be 
so advised and told to report immediately any signs or symptoms suggesting 
angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in 
swallowing or breathing) and to take no more drug until they have consulted 
with the prescribing physician. 
Hypotension: Patents should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the 
patients should be told to discontinue the drug until they have consulted 
with the prescribing physician.

with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to con-

sulf with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing

Hyperkalenia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropevia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia. Pregunary: Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible.

NOTE: As with many other drugs, certain advice to patients being treated with VASERETIC is warranted. This information is intended to ad in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug hiteractions: Enalapril Maleate; Hypolension—Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was

Drug Interactions; Enalapril Malaete; Hypotension—Patients on Diuretic Therapy. Patients on diuretic and especially those in whom diuretic therapy was recently instituted, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to onthinue the diuretic, provide medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS.)

\*\*Agents Causing Renin Release: The antihypertensive effect of enalapril is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: Enalapril has been used concomitantly with beta adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine and prazosin without evidence of clinically significant

agents, hydralazine and prazzsin winduct evidence of chinary significant adverse interactions.

Agents Increasing Serum Potassium: Enalapril attenuates diuretic-induced potassium loss. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing, ast substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypotalemia they should be used with caution and with frequent monitoring of serum potassium.

Lithium: Lithium toxicity has been reported in patients receiving concomitant with order which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant enalapril and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concurrently the following drugs may interact with thiazide diuretics:

Alcoho, barbiturates, or narcotics—potentiation of orthostatic hypotension

Alcohol, barbiturates, or narcotics-potentiation of orthostatic hypote

Antituberic urugs (trai agents and insum)—uosage acquisiment or the antidiabetic drug may be required.

Other antihippertensive drugs—additive effect or potentiation.

Cholestynamine and colestipol resins—Absorption of hydrochlorothiazide is impaired in the presence of anionic exchange resins. Single doses of either toolestyramine or colestipol resins bind the hydrochlorothiazide and reduce its absorption from the gastrointestinal tract by up to 85 and 43 percent, respectively.

Corticosteroids, ACTH—intensified electrolyte depletion, particularly

hypokaenna. Pressor amines (e.g., norepinephrine)—possible decreased response to pressor amines but not sufficient to preclude their use.

Skeletal muscle relaxants, nondepolarizing (e.g., tubocurarine)—possible increased responsiveness to the muscle relaxant.

increased responsiveness to the muscle relaxant. Lithium—should not generally be given with diuretics. Diuretic agents reduce the renal clearance of lithium and add a high risk of lithium toxicity. Refer to the package insert for lithium preparations before use of such preparations with VASERETIC. Non-strondal Anti-inflammatory Druge—In some patients, the administration of a non-steroidal anti-inflammatory agent can reduce the diuretic, natriuretic, and only become control of a non-steroidal anti-inflammatory agent can reduce the diuretic, natriuretic, and only become control of the c

and antihypertensive effects of loop, potassium-sparing and thiazide diuretics. Therefore, when VASEKETIC and non-steroidal anti-inflammatory agents are used concomitantly, the patient should be observed closely to determine if the desired effect of the diuretic is obtained.

desired effect of the diurebic is obtained. Carcinogenesis, Mulagenesis, Impairment of Fertility: Enalapril in combination with hydrochlorothiazide was not mutagenic in the Ames microbial muta-gen test with or without metabolic activation. Enalapril-hydrochlorothiazide did not produce DNA single strand breask in an in vitro alkaline elution assay in rat hepatocytes or chromosomal aberrations in an in vivo mouse

bone marrow assay. Emalapril Mallattr: There was no evidence of a tumorigenic effect when enalapril was administered for 106 weeks to rats at doses up to 90 mg/kg/day (150 times" the maximum daily human dose). Enalapril has also been administered for 94 weeks to male and female mice at doses up to 90 and 180 mg/kg/day, respectively, (150 and 300 times" the maximum daily dose for humans) and showed no evidence of car-

has also been administration of weeks to make and remale mice at closes up to what to soling /kg/day, respectively, (TS) and 300 times" the maximum daily dose for humans) and showed no evidence of acricinogenicity.

Neither enalapril maleate nor the active diacid was mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril was also negative in the following genotoxicity studies: rec-assay, reverse mutation assay with £. colf, sister chromatid exchange with cultured mammalian cells, and the micronucleus test with mice, as well as in an in vivo cytogenic study using mouse bone marrow. There were no adverse effects on reproductive performance in male and female rats treated with 10 to 90 mg/kg/day of enalapril.

Hydrochlorothiazide: Two-year feeding studies in mice and rats conducted under the auspices of the National Toxicology Program (NTP) uncovered no evidence of a carcinogenic potential of hydrochlorothiazide: in female mice (at doses of up to approximately 600 mg/kg/day) or in male and female rats (at doses of up to approximately 100 mg/kg/day). The NTP, however, found equivocal evidence for hepatocarcinogenicity in male mice.

Hydrochlorothiazide was not genotoxic in vitro in the Ames mutagenicity assay of Salmonella trability in the strain of the strain of

tration.

Hydrochlorothiazide had no adverse effects on the fertility of mice and rats of either sex in studies wherein these species were exposed, via their diet, to doses of up to 100 and 4 mg/kg, respectively, prior to conception and throughout gestation.

Preguancy Preguancy Categories C (first trimester) and D (second and third trimesters). See WARNINGS, Preguancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.

Nursing Mothers: Enalapril and enalaprilat are detected in human milk in trace amounts. Thiazies dappear in human milk. Because of the potential for serious reactions in nursing infants from either drug, a decision should be made whether to discontinue nursing or to discontinue VASERETIC, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: VASERETIC has been evaluated for safety in more than 1500 patients, including over 300 patients treated for one year or more. In clinical trials with VASERETIC no adverse experiences peculiar to this combination drug have been observed. Adverse experiences that have occurred, have been limited to those that have been previously reported with enalapril or hydrochlorothiazide.

experiences peculiar to this combination drug have been observed. Adverse experiences that have occurred, have been limited to those that have been previously reported with enalapril or hydrochlorothazide.

The most frequent clinical adverse experiences in controlled trials were: dizziness (8.6 percent), headache (5.5 percent), fatigue (3.9 percent) and cough (3.5 percent). Adverse experiences occurring in greater than two percent of patients treated with VASERETIC in controlled clinical trials were: muscle cramps (2.7 percent), and diarrhea (2.1 percent). expercent), orthostatic effects (2.3 percent), impotence (2.2 percent), and diarrhea (2.1 percent). Clinical adverse experiences occurring in 0.5 to 2.0 percent of patients in controlled trials included: Body As A Whole: Syncope, chest pain, abdornianal pain; Cardioviscular: Orthostatic hypotension, palpitation, tachycardia; Digestire: Vomiting, dyspepsia, constipation, flatulence, dry mouth; Nervous/Psychiatric: Insonnia, nervousness, paresthesia, somnolence, vertigo, Stir: Prurinis, rash, Other: Dyspnea, gout, back pain, arthralgia, diaphoresis, decreased libido, tinnitus, urinary tract infection.

Angioedemia: Angioedemia has been reported in patients receiving VASERETIC (0.6 percent), Angioedemia associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis and/or larynx occurs, treatment with VASERETIC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS).

Hypotension: In clinical trials, adverse effects relating to hypotension occurred as follows: hypotension (0.9 percent), orthostatic hypotension (1.5 percent), other orthostatic effects (2.3 percent). In addition syncope occurred in 1.3 percent of patients. (See WARNINGS).

Cough: See PRECAUTIONS. Cough:

Clinical Laboratory Test Findings; Serum Electrolytes: See PRECAUTIONS.

Creatinine. Blood Uran Nitrogen: In controlled clinical trials minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinu

patients with researchian hyperteistorit teateur with VASEATIC. White makes interesses have been reported in other enalapril experience. Increases are more likely to occur in patients with renal artery stenosis. (See PRECAUTIONS).

Serum Utra Acid, Clucose, Magnesium, and Calcium: See PRECAUTIONS.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g. percent and 1.0 vol percent, respectively) occur frequently in hypertensive patients treated with VASEAETIC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1 percent of patients discontinued therapy due to anemia.

Liter Function Tests: Rarely, elevations of liver enzymes and/or serum bilirubin have occurred. Other adverse reactions that have been reported with the individual components are listed below and, within each category, are in order of decreasing seventy.

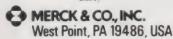
Evalupril Maleate—Enalapril has been evaluated for safety in more than 10,000 patients. In clinical trials adverse reactions which occurred with enalapril were also seen with VASEAETIC. However, since enalapril has been marketed, the following adverse reactions have been reported: Body As A Whole: Anaphylactoid reactions (see PRECAUTIONS, Hemodialysis Patients); Cardiovascular: Cardioa rest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high risk patients (see WARNINGS, Hypotension); pulmonary embolism and infarction, pulmonary edema, rhythm disturbances including athal tachycardia and bradycardia, artal fibrillation, hypotension; anging apectors; Digestrie: Ileus, parcreatitis, hepatic failure, hepatitis (hepatocellular [proven on rechallenge] or cholestatic aundice), melena, anorexia, glossitis, stomatitis, dry mouth, Hematologic, Rare cases of neutropenia, thrombocytopenia and bone marrow depression. Hemolytic anemia, including cases of hemolysis in patient with G-6-D deficiency, has been reported; a causal relationship to enalap

Fetal/Neonatal Morinitity and Mortality: See WARNINGS, Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.

Hydrochlorothiazide—Body as a Whole: Weakness; Digestive: Pancreatitis, jaundice (intrahepatic cholestatic jaundice), sialaderuitis, cramping, gastric irritation, anorexia, Hennologic: Aplastic aremia, agranulocytosis, leukopenia, henolytic anemia, thrombocytopenia, Hypersensitivity: Purpura, photosensitivity, urticaria, necrotizing angilist (vasculitis and cutaneous vasculitis), lever, respiratory distress including pneumonitis and pulmonary edema, anaphyladic reactions; Musculoskelfai: Muscle spasmy, Nervous SystemiPsychiatric. Restlessness, Renai: Renal failure, renal dysfunction, interstitial nephritis (see WARNINGS); Skin: Erythema multiforme including Severa-Johnson syndrome, exfoliative dermatitis including toxic epidermal necrolysis, alopecia; Special Senses: Transient blurred vision, xanthopsia.

\* Based on patient weight of 50 kg.

For more detailed information, consult your DuPont Pharma Representative or see Prescribing Information.



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**Guest speakers will include national** emergency/trauma care experts covering multidisciplinary trauma management and health policy topics.

CME credit: 9.5 credit hours of Category 1 of the Physicians Recognition Award of the American Medical Association and the State of Michigan relicensure requirements.

**Call Douglas Beaudoin** at (313) 993-0075 for registration information.



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### **Final Program Issue**





Michigan State Medical Society

1993 ANNUAL SCIENTIFIC MEETING

November 9,10 & 11, 1993

Westin Hotel, Renaissance Center, Detroit

### "Medicine Moving in New Directions"

ear Colleague:

"Medicine Moving in New Directions" is the perfect theme for the 1993 MSMS Annual Scientific Meeting for many exciting reasons.

In addition to the traditional quality classes, we have:

- a new and expanded location at the Westin Hotel;
- more "hands-on" programs and classroom demonstrations;
- three free plenary sessions on health system reform, breast cancer and prostate cancer;
- more than 50 half-day programs offering up to 20 Category I CME credits during the three-day meeting;
- special events including specialty society meetings, a visit to The Second City comedy club, an evening program on "Reclaiming the Joy of Medicine" and a conference on domestic violence.

The ASM Planning Committee, with the cooperation of specialty societies, medical schools and hospitals has put together a tremendous program. They have planned the details of this year's meeting with one purpose in mind-to provide a high standard of educational opportunities, at a reasonable cost, for Michigan physicians.

The quality of programming at the Michigan State Medical Society's 128th Annual Scientific Meeting reflects their commitment to that purpose.

Hope to see you there.

Sincerely,

Lillet B. Bluhm MD

Gilbert B. Bluhm, MD

President

#### What's Where

| Welcome                          | 20 |
|----------------------------------|----|
| Capsule Schedule                 | 21 |
| New Directions & Special Events  | 23 |
| General Information              | 25 |
| Course Schedule                  | 27 |
| Exhibitor Map & Information4     | 40 |
| List of Exhibitors4              | 41 |
| Floor Plans4                     | 42 |
| Cooperating Specialty Societies4 | 45 |
| Expanded Programming4            | 46 |
| Registration Form                | 47 |

# And Special Events

#### Monday, November 8, 1993

9:00 a.m. - 4:00 p.m.

First Annual Rhodes Lecture on Family Medicine

10:00 a.m. - 4:00 p.m.

AIDS Provider Education Update

6:00 p.m. - 9:00 p.m.

Reclaiming the Joy of Medicine Dinner Reception/Presentation

#### Tuesday, November 9, 1993

7:15 a.m. - 8:15 a.m.

Free "Early Bird" Plenary Session

"Health System Reform: The Physician's Role"

8:00 a.m. - 9:30 a.m.

Exhibitor "Welcome" Breakfast and "The Dynamics of Medical Show Exhibiting" - open to all ASM exhibitors

#### 8:30 a.m. - 12:00 noon

#### **Concurrent Scientific Courses**

- Basic Cardiac Life Support
- Current Issues in Environmental Health
- 50 Ways to Relieve Physician Stress and Create a Healthier Practice
- Health Care Reform: What Are the Implications for My Patients and for the Future of My Medical Practice?
- HIV: The Debate on Written Informed Consent Requirements
- Primary Care of Injured Athletes
- Radiology for Clinicians
- Recognizing and Diffusing the Potentially Violent Patient
- What's New About Alzheimer's Disease?

#### 12:00 Noon

Lunch Recess/Exhibit Hall Activities

12:00 Noon - 1:30 p.m.

MSMS/MPMLC Closed Claim Review Session - General Medicine

#### 1:30 p.m. - 5:00 p.m.

#### **Concurrent Scientific Courses**

- Common Abdominal Problems in Children
- Computers in Medicine (Basic Level)
- Domestic Violence The Seguel
- Life Threatening Adverse Drug Reactions
- Management of Diabetes Mellitus: Impact of the DCCT
- Rehabilitation of the Injured Athlete
- Tuberculosis: An Old Problem with New Faces
- Update on Hypertension

#### 6:30 p.m.

"Night of 1,000 Laughs" at the Second City, Detroit Dinner Reception/Performance

#### Wednesday, November 10, 1993

7:00 a.m. - 8:30 a.m.

MSMS/MPMLC Closed Claim Review Session - Allergy MSMS/MPMLC Closed Claim Review Session - Dermatology

7:15 a.m. - 8:15 a.m.

Free "Early Bird" Plenary Session

"The Genetics of Breast Cancer"

#### 8:30 a.m. - 12:00 Noon

#### **Concurrent Scientific Courses**

- Anaphylaxis: Pathophysiology, Etiology, Clinical Characteristics and Treatment
- Basic Cardiac Life Support
- Clinical Problems in Fluid, Electrolyte and Acid-Base Disorders
- Computers in Medicine (Basic Level)
- Improving Physician/Patient Communication Skills
- Office Management of Common Foot and Ankle Disorders
- Primary Care After 50
- Progress in Neurosurgery for the 21st Century (Part I)
- Update on the Treatment of BPH

Continued on following page

# And Special Events

#### 12:00 Noon

Lunch Recess/Exhibit Hall Activities

#### Luncheon

MSMS Committee on Concerns of Women Physicians

#### Luncheon

MSMS Committee of Specialty Society Presidents

#### 1:30 p.m. - 5:00 p.m.

#### **Concurrent Scientific Courses**

- Computers in Medicine (Advanced Level)
- Contraception for Women of All Ages
- Dermatologic Diagnosis and Therapy
- Evaluation and Management of Pediatric and Adolescent Spinal Deformities
- Management of Asthma Problems
- Management of Neoplasms of Colorectum: Strategies for the 90's
- Management of Urinary Incontinence
- Primary Care for People with Disabilities
- Progress in Neurosurgery for the 21st Century (Part II)

#### 1:30 p.m. - 5:00 p.m.

Exceptional Leadership Skills MSMS/BCBSM Automated Billing Update

#### 3:00 p.m.

Michigan Orthopaedic Society Board Meeting/Reception/Dinner

#### 4:00 p.m.

Michigan Society of General Surgeons Meeting/Reception

#### 6:00 p.m.

Wayne State University School of Medicine Alumni Reception

#### 6:30 p.m.

Michigan Society of Colon and Rectal Surgeons Reception

#### Thursday, November 11, 1993

#### 7:15 a.m. - 8:15 a.m.

#### Free "Early Bird" Plenary Session

"The Evaluation and Management of Prostate Cancer"

#### 8:30 a.m - 12:00 Noon

#### **Concurrent Scientific Courses**

- A Short Course in Vascular Surgery
- Basic Cardiac Life Support
- Current Management of Sinusitis
- Evaluation and Treatment of Arthritic Disorders of the Shoulder and Elbow
- Fetal and Perinatal Wound Healing and Surgery
- Newer Guidelines for Therapy in Cardiovascular Surgery
- Respiratory Update for the Practicing Physician
- The Peptic Ulcer: A Changing Disease

#### 8:30 a.m. - 12:00 Noon

Risk Management for the Medical Office Staff Practical Solutions for Healthier Eating

#### 12:00 Noon

Lunch Recess/Exhibit Hall Activities

#### 1:30 p.m. - 5:00 p.m.

#### **Concurrent Scientific Courses**

- A Multidisciplinary Approach to Management of the Obese Patient
- Common Problems in Nephrology
- Diagnosis and Management of Pulmonary Embolism
- Diagnosis and Non-Operative Treatment of Lumbar Radiculopathies
- Environmental Medicine for the Practicing Physician
- Nutritional Treatment for Cardiovascular Risk Factor Reduction
- Psychiatric Side Effects of Medical Drugs and Medical Effects of Psychiatric Drugs
- Primary Care and the Educational System
- Update in Plastic Surgery Procedures

#### 6:00 p.m.

Michigan Occupational & Environmental Medical Association

Reception/Dinner

# MSMS Annual Scientific Meeting, November 9,10 & 11, 1993

#### **AIDS Provider Education Update**

Once again, the MSMS AIDS Provider Education Project will present its Annual Speakers Bureau update in conjunction with the MSMS Annual Scientific Meeting. Over 100 qualified representatives will be apprised of the most current information regarding HIV, AIDS, and AIDS education during this special session on Monday, November 8, 1993. For further information regarding this program, contact Tracy Baker, MSMS Coordinator of AIDS Education, (517) 336-5770.

Michigan and Florida CME Credit Available. The task force also will sponsor its annual clinical course. This year's program is entitled "HIV: The Debate on Written Informed Consent Requirements," and will be offered on Tuesday morning. Completion of this course will earn 3 hours of Category I CME for Michigan relicensure, and will fulfill partial requirements for Florida's requisite AIDS education.

#### **Domestic Violence Programs**

Continuing the Michigan State Medical Society's efforts to lessen the incidence of violence in both domestic and medical settings, this year's conference will include Tuesday courses on "Domestic Violence - The Sequel" and "Recognizing and Diffusing the Potentially Violent Patient."

A one-day conference to develop hospital-based family violence programs also will be offered in conjunction with the Annual Scientific Meeting. It will be held at the Wayne County Medical Society on Monday, November 8, from 9:00 a.m. - 4:00 p.m. For further information or to register, call Judy Marr or Joyce Heldman at MSMS, (517) 336-5745.

#### Expanded Programming for Medical Office Staff and Alliance

Invite your medical office staff and/or spouse to attend the MSMS Annual Scientific Meeting with you! Programming will include risk management for the office staff, leadership training, patient communication skills, and a special presentation on nutritional shopping and cooking. For further information or to register for these events, see the expanded programming form on page 46.

Invite your staff, spouse and colleagues to visit the exhibit hall and the new Practice Management Pavilion—whether they register to attend the educational courses or not! Complimentary exhibit hall passes are available to all Michigan physicians and their medical office staff. Two exhibit hall passes will be sent with your confirmation

packet. If you need more, or are not registered for the conference, simply call the MSMS Office of Physician Education at (517) 336-5784.

#### **Annual Sports Medicine Conference**

Once again, the Michigan State Medical Society, in cooperation with the Michigan Orthopaedic Society, Michigan Athletic Trainers Association, and the Michigan High School Athletic Association, is offering several half-day sessions on Sports Medicine during the 1993 Annual Scientific Meeting. This separate "conference within a conference" should be of value to physicians, coaches, trainers and allied professionals who have an interest in improving the care and performance of athletes. CME approved courses on "Primary Care of Injured Athletes," and "Rehabilitation of the Injured Athlete" will be offered on Tuesday, November 9. For further information on these or other related courses, refer to the individual course descriptions.

#### New Features in the Exhibit Hall

A larger exhibit hall at the Westin allows for a wider selection of health care products and services to be on display from 7:00 a.m. -5:30 p.m. daily. In addition, watch for these new features:

Free Practice Management Consulting Services. Visit an all new Practice Management Pavilion in the center of the MSMS exhibit hall. Free consulting services will be provided to answer your legal, marketing, billing, regulatory and other practice management questions. Be sure to stop by and visit this informative and visual display.

MSMS Cafe. Another highlight in the exhibit hall this year will be the all-new MSMS Cafe. In addition to free coffee provided by MSMS, several vendors will offer morning refreshments, a variety of lunch time selections, and afternoon beverages and refreshments for purchase. You can choose what you want and determine how much you want to spend, then relax in the convenient dining area provided in the MSMS exhibit hall.

# MSMS Annual Scientific Meeting, November 9, 10 & 11, 1993

For Physicians and Their Spouses

#### "Reclaiming the Joy of Medicine"

Sponsored by the MSMS Task Force on Physician Well-Being

#### Monday, November 8, 1993

Detroit Renaissance Club 6:00 p.m. Registration, Cash-Bar 6:30 p.m. Dinner Reception 7:30 p.m. Program

Take time out to provide for your own physical and mental health. Attend a special dinner presentation for physicians and their spouses entitled "Reclaiming the Joy of Medicine," sponsored by the MSMS Task Force on Physician Well-Being. This event, held at the private Detroit Renaissance Club in the Renaissance Center, will feature guest speaker John-Henry Pfifferling, PhD, from the Center for Professional Well-Being in Durham, North Carolina.

Register for this event on the registration form. Tickets are \$40 per person, includes dinner and program.

1st Annual Francis P. Rhoades, MD, Memorial Lecture

### "The Team Approach to the Silence of Violence: Developing Hospital-Based Family Violence Programs"

Jointly-sponsored by the MSMS, Wayne County Medical Society, Oakland County Medical Society and Michigan Hospital Association

#### Monday, November 8, 1993

Wayne County Medical Society headquarters 1010 Antietam, Detroit 9 a.m. to 5 p.m.

Join your physician colleagues, nurses, administrators, social workers and others and learn from top national speakers how to develop hospital-based programs for domestic violence victims.

The MSMS Committee on CME Programming certifies that this activity meets the criteria for a maximum of 7 hours of Category I credit toward the requirements for Michigan relicensure and of the Physician Recognition Award of the AMA, provided it is completed as designated.

Registration is \$75 per person. To register, contact Joyce Heldman at MSMS, 517/336-5745.

For Physicians, Residents, Students, Medical Office Staff, Legislators and Their Invited Guests

#### "Night of 1,000 Laughs"

Sponsored by MSMS and MDPAC

#### Tuesday, November 9, 1993

The Second City, Detroit 6:30 p.m. Dinner Reception 7:30 p.m. Program



Join your colleagues for a special evening of laughter and fun at Detroit's new "The Second City" improvisation comedy club. Just a short PeopleMover ride away, this new theater club creates a slice-of-life environment, lampooning modern lives with the use of music and laughter, instead of complicated props or costumes.

Michigan State Medical Society and the political action committee MDPAC will sponsor this "Night of 1000 Laughs." A dinner reception for conference participants, MDPAC members, community leaders and legislators begins at 6:30 p.m. The Second City performance begins at 7:30 p.m. Register for this event on the MSMS Registration Form on the inside back cover.

Dinner Reception and Second City Tickets:
For MDPAC Sustaining and Family Members –
\$15 per person
For All Others - \$40 per person

For All Others - \$40 per person Second City Tickets Only: \$15 per person

#### **ASM Planning Committee**

Dorothy M. Kahkonen, MD, Detroit, Chair Tama D. Abel, MD, Ann Arbor Rudi Ansbacher, MD, Ann Arbor Delores Berrien-Jones, MD, Taylor Frederick W. Bryant, MD, Troy Miriam Daly, MD, Albion Nicholas J. Lekas, MD, Dearborn David J. Millard, MD, Paw Paw Kamran S. Moghissi, MD, Detroit Conrad E. Nagle, MD, Troy Anthony Senagore, MD, Grand Rapids Atul C. Shah, MD, Royal Oak Evangeline J. Spindler, MD, Ann Arbor Joan C. Stryker, MD, Detroit Greg Ott, ATC, Ann Arbor

# MSMS Annual Scientific Meeting

**Registration:** The registration desk will be located in the Ontario Exhibit Hall, Third Floor, Westin Hotel, Renaissance Center, Detroit.

**Adopt-a-Doctor:** The ASM Planning Committee looks forward to continued participation by the hundreds of physicians who attend the MSMS Annual Scientific Meeting each year. Your efforts in promoting the meeting to your colleagues and the participation by more first-time attendees each year has resulted in the Adopt-a-Doctor discount program. You may take \$20 off your registration total if you bring a physician who has never attended (or if you have never attended) an MSMS Annual Scientific Meeting.

**Free Parking:** Secured parking at designated lots near the Renaissance Center will be provided free of charge to all ASM registrants. Detailed parking maps will be sent with your confirmation and parking vouchers will be presented to you at the ASM Registration Desk.

**MSMS Message Center:** Special telephone lines will be installed for incoming, local and long distance calls. Just call the Westin Hotel, 313/548-8000 and ask for the MSMS Message Center, or if you are a Cellular One user you may dial \*MSMS and be directly connected with the Westin. Be sure to check the Message Board at the MSMS Registration Desk regularly for posted messages.

**Coat Check:** A complimentary coat check will be available adjacent to the MSMS Registration Desk and will operate at the same times. Please remember to pick up your coat before going to any evening functions. Items left at the coat check after 5:30 p.m. will be locked away until the following morning.

**Admission to Courses:** Admission will be by Course Admission Tickets, which will be given to physicians when they register. No one will be admitted to courses without tickets and/or badges. All courses begin promptly at 8:30 a.m. or 1:30 p.m.

**Faculty Headquarters:** Course directors and instructors can use the Michelangelo Room on the Fourth Floor as a place to meet, review slides or course material, etc.

**No Smoking Please:** All participants are asked to refrain from smoking while courses are in session. There will be a half-hour break in all courses. The no-smoking policy has been in effect since 1977.

**Free Coffee:** Coffee will be available in the Exhibit Hall. Plenary sessions will have coffee available in the rear of the room.

**MSMS Cafe:** In addition to free coffee provided by MSMS, several vendors will offer morning refreshments, a variety of lunch time selections, and afternoon beverages and refreshments for purchase. You can choose what you want and determine how much you want to spend, then relax in the convenient dining area provided in the MSMS exhibit hall.

**Exhibit Center:** Participants are urged to visit the outstanding displays featured in the Ontario Exhibit Hall and to express their support for the exhibitors' financial contribution to the meeting. Exhibits are open from 7:00 a.m. to 5:30 p.m. on Tuesday and Wednesday, and from 7:00 a.m. to 3:45 p.m. on Thursday.

**Exhibit Hall Passes:** Free passes are available for registered participants to invite their colleagues and/or staff to visit the exhibit hall.

**Practice Management Pavilion:** Visit an all-new Practice Management Pavilion in the center of the MSMS Exhibit hall. Free consulting services will be provided to answer your legal, marketing, billing, regulatory and other practice management questions. Be sure to stop by and visit this informative and visual display.

# November 9, 10 & 11, 1993, Westin Hotel, Renaissance Center, Detroit



**Category I Credits:** The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, designates this activity meets the criteria for a maximum of 20 credit hours in Category I toward the requirements for Michigan relicensure and of the Physician Recognition Award of the AMA, provided it is completed as designed.

Certificates of Participation in Category I CME courses will be provided to physicians at the end of each course. Physicians should keep these certificates on file as proof of their attendance.

**Media:** Medical writers and representatives of television and radio have been invited to cover the Annual Scientific Meeting. MSMS staff will be available all three days in the Michelangelo Room to provide assistance. Press releases will be provided for participants to complete and forward to their own local media.



#### **Life Support Station:**

The MSMS Annual Scientific Meeting, in cooperation with the Michigan College of Emergency Physicians, is prepared to handle medical emergencies of all its participants that may occur within the physical confines of the Westin Hotel, Detroit. A Life Support Station is staffed Tuesday through Thursday during the hours of the meeting by emergency medicine residents from area hospitals and by nurses and/or paramedics from the Lansing area.

In Case of Emergency...In the Westin Hotel, Renaissance Center, Detroit, CALL 8609, Tuesday through Thursday, from 8:00 a.m. to 5:30 p.m., or go to the Life Support Station just outside the Ontario Exhibit Hall on the Third Floor. AT ALL OTHER TIMES CALL 0 AND STATE THE EMERGENCY. Please read carefully the following:

- 1. If an emergency (e.g., cardiac arrest) occurs during the hours the Station is open, proceed to the nearest telephone and call 8609. State the floor, area and room the patient is in and the nature of the problem as well as the number of the phone from which you are calling.
- 2. When the Life Support team arrives, they will assume command of the emergency care. Do not interfere or offer assistance unless asked to do so. Assist with crowd control and open a passageway for evacuation of the patient.
- **3.** Do NOT summon an ambulance or call the hospital as this will be done by the team.
- **4.** Persons needing medical attention may come directly to the Life Support Station.
- **5.** Robert K. Orr, Jr., DO, is the director of the Life Support Station. Inquiries concerning Life Support Station operation should be directed to him.

MSMS thanks the following for contribution of equipment and supplies to the Life Support Station:

Lansing Mercy Ambulance Service St. Lawrence Hospital, Lansing Physio-Control, Grand Rapids

# November 9, 10 & 11, 1993, Westin Hotel, Renaissance Center, Detroit

#### **Tuesday Morning, November 9**

All courses run from 8:30 a.m. to Noon with a half-hour break

**No Charge for this "Early Bird" Plenary Session**Complimentary Coffee Available at 7:00 a.m.
MSMS Cafe Open for Refreshments at 7:00 a.m.

### "Successful Health System Reform: The Physician's Role"

Leonard Fleck, PhD, Associate Professor of Medical Ethics and Health Policy, Michigan State University College of Human Medicine.

This special plenary session will use the latest in computer technology to explore the physician's role in shaping successful health system reform. The program will provide current information regarding state and national health care initiatives, as well as seek your opinions and answer your questions through the use of a computerized, interactive audience response system.

#### **Basic Cardiac Life Support**

PRESENTED BY: St. Lawrence Hospital and Michigan College of Emergency Physicians

This course will include lectures and practical situations for teaching Basic Cardiac Life Support according to the American Heart Association guidelines. The session includes hands-on teaching of cardiopulmonary resuscitation, obstructed airways in unconscious and conscious victims, including infants and CPR. A BCLS card or Heart Saver Card will be presented upon completion.

COURSE DIRECTOR: Robert K. Orr, Jr., DO, Vice Chief, Department of Emergency Medicine, St. Lawrence Hospital, Lansing

PRESIDING: Doctor Orr

#### **Current Issues in Environmental Health**

PRESENTED BY: MSMS Task Force on Environment and Health

This course will provide primary care physicians with an approach to environmental health problems. Presenters will specifically discuss water and air pollution, as well as solid waste management.

COURSE DIRECTOR: James E. Blessman, MD, MPH, Assistant Professor, Wayne State University School of Medicine, Department of Family Medicine

PRESIDING: Doctor Blessman

#### 50 Ways to Relieve Physician Stress and Create a Healthier Practice

PRESENTED BY: MSMS Task Force on Physician Well-Being

This course will focus on ways to relieve physician stress and to provide better patient care. A panel of practicing physicians will be interviewed by John-Henry Pfifferling, PhD, in order to analyze the unique stressors in a physician practice, and to provide suggestions for relieving that stress. The focus will be on stressors that get in the way of providing optimal patient care, and will provide specific suggestions for creating a healthier practice.

COURSE DIRECTOR: Carl F. Hammerstrom, Jr., MD, Chairman, MSMS Task Force on Physician Well-Being

PRESIDING: Doctor Hammerstrom

### Health Care Reform: What Are the Implications for My Patients and for the Future of My Medical Practice?

PRESENTED BY: MSMS Physician Organizations Committee

This course will feature a panel presentation including representatives from state and federal task forces, government, business, and physician and physician/hospital organizations. They will explore recent and anticipated changes in the health care environment and relate these changes to

27

# Westin Hotel, Renaissance Center, Detroit

methods for insuring physician control over the clinical aspects of medicine, using a computerized, interactive audience response system and responses from the early-morning plenary session.

COURSE DIRECTOR: Fred R. Patterson, MD, Chairman, MSMS Physician Organizations Committee

PRESIDING: Leonard Fleck, PhD, Associate Professor of Medical Ethics and Health Policy, Michigan State University College of Human Medicine

#### HIV: The Debate on Written Informed Consent Requirements

PRESENTED BY: MSMS AIDS Provider Education Project

This course is designed to explore the various positions taken on current written informed consent requirements for HIV testing. A lecture tracing the role of informed consent in the practice of medicine will be included, as well as discussions of current Michigan law on informed consent and an overview of the epidemiology of HIV. A panel discussion will be held.

COURSE DIRECTOR: David B. Martin, MD, Chairman, MSMS AIDS Provider Education Task Force

PRESIDING: Doctor Martin

#### **Primary Care of Injured Athletes**

PRESENTED BY: MedSport, University of Michigan Medical Center

This course will present techniques of evaluating, treating and rehabilitating athletic injuries as they might present to primary care providers. Specifically, it will address common areas of injury including the elbow, shoulder, wrist, knee, foot, and ankle. Indications for surgical treatment will be mentioned, but not discussed in detail. It is geared toward primary care physicians who care for injured athletes in their practice or as team physicians.

COURSE DIRECTOR: James E. Carpenter, MD, Instructor, Department of Orthopaedic Surgery, MedSport, University of Michigan Medical Center

PRESIDING: Doctor Carpenter

#### **Radiology for Clinicians**

PRESENTED BY: Department of Radiology, Wayne State University School of Medicine

The course will consist of three presentations dealing with the radiological evaluation and/or detection of common malignancies: breast, lung and various abdominal malignancies. A fourth presentation will describe various radiological manifestations of AIDS.

COURSE DIRECTOR: A. P. Zingas, MD, FACR, Associate Professor of Radiology, Wayne State University School of Medicine

PRESIDING: Doctor Zingas

#### Recognizing and Diffusing the Potentially Violent Patient

PRESENTED BY: Washtenaw County Medical Society

This course will provide information about the types of individuals who are usually involved in assaults on physicians and other health care personnel. How to address these problems in various settings will be discussed, including simple self-defense tactics.

COURSE DIRECTOR: Rhoda Powsner, MD, Washtenaw County Medical Society

PRESIDING: Doctor Powsner

#### **Tuesday Afternoon, November 9**

All courses run from 1:30 p.m. to 5:00 p.m. with a half-hour break

#### What's New About Alzheimer's Disease?

PRESENTED BY: Michigan Alzheimer's Disease Research Center, Alzheimer's Association, Michigan Council

This course will explain how to recognize dementia and the importance of an accurate diagnosis of Alzheimer's disease. Current and future treatment of the disease will be discussed. Faculty representing the developing network of services to patients with dementia and their families in Michigan will discuss the importance of community, autopsy and geriatric assessment services to the disease.

COURSE CO-DIRECTORS: Sara B. Holmes, MPH, Senior Health Educator for the Education and Information Transfer Core, Michigan Alzheimer's Disease Research Center, and Norman Foster, MD, Associate Director, Michigan Alzheimer's Disease Research Center, Ann Arbor

PRESIDING: Ms. Holmes and Doctor Foster

# All courses offer 3 hours of Category I CME Credit

#### Common Abdominal Problems in Children

PRESENTED BY: Pediatric Ambulatory Care, University of Michigan Medical School

This course will review and update the evaluation, management and treatment of infants, children and adolescents who may have colic, acute and chronic diarrhea, constipation or encopresis, recurrent abdominal pain and chronic or recurrent episodes of vomiting. The differential diagnosis of these problems will be emphasized, along with a practical approach to management.

COURSE DIRECTOR: Craig Hillemeier, MD, Associate Professor, Division of Pediatric Gastroenterology, University of Michigan Medical School

PRESIDING: Doctor Hillemeier

#### **Computers In Medicine (Basic Level)**

\* This Limited Attendance Workshop is a smaller, handson program with a \$75.00 course fee.

PRESENTED BY: Department of Medical Education, Oakwood Hospital, Dearborn

This course will introduce the practicing physician to the power of computers in medicine. Basic computer skills, including principles of DOS and word processing will be presented as will the use of literature search and differential diagnosis programs. Time will be provided for the participating physicians to explore these programs in a live computer laboratory.

COURSE DIRECTOR: Nicholas Lekas, MD, FACP, Director, Internal Medicine Residency, and Department of Medical Education, Oakwood Hospital, Dearborn

PRESIDING: Doctor Lekas

#### **Domestic Violence - The Sequel**

PRESENTED BY: Michigan State Medical Society Alliance

This course is designed to assist practitioners in managing known and suspected cases of domestic and adolescent violence. The attendee will receive instruction in recognizing signs of abuse, interviewing to ascertain potentially violent situations, current and developing Michigan law regarding abuse cases, how to work expeditiously within the legal system, and developing community networks to provide victim services.

COURSE DIRECTOR: Thomas C. Payne, MD, MSMS Past-President; Radiologist, Lansing Radiology, PC

#### **Life-Threatening Adverse Drug Reactions**

PRESENTED BY: Michigan College of Emergency Physicians

This course will review basic concepts in clinical pharmacology. Case presentations/discussion will then apply these concepts to both adult and pediatric patients. Proper dosing and avoidance of common drug side effects and drug-drug interactions will be the focus of this course.

COURSE DIRECTOR: James E. Cisek, MD, Department of Emergency Medicine, Wayne State University School of Medicine

PRESIDING: Doctor Cisek

#### **Management of Diabetes Mellitus: Impact of the DCCT**

PRESENTED BY: American Diabetes Association, Michigan Affiliate and Division of Endocrinology, Wayne State University School of Medicine

This course will review the design, management, and outcomes of the Diabetes Control and Complication Trial, an NIH, multi-centered study of the effects of intensive therapy on the complications of insulin-dependent diabetes mellitus.

COURSE DIRECTOR: Scott Jacober, DO, Assistant Professor, Department of Medicine, Wayne State University School of Medicine

PRESIDING: Doctor Jacober

#### **Rehabilitation of the Injured Athlete**

PRESENTED BY: MedSport, University of Michigan Medical Center

This course will provide primary care providers with principle rehabilitation techniques for athletic injuries. It will address: 1) tendonitis, impingement, separation and dislocations of the shoulder; 2) sprains, tendonitis, and patellofemoral syndromes of the knee; 3) sprains, strains, fractures, and overuse injuries to the ankle; and 4) common overuse injuries seen in athletics, rehabilitating these at home.

COURSE CO-DIRECTORS: Gregory A. Ott, PT, ATC, Director of Physical Therapy and Athletic Training, MedSport, University of Michigan Medical Center, and; James E. Carpenter, MD, Instructor, Department of Orthopaedic Surgery, MedSport, University of Michigan Medical Center

PRESIDING: Mr. Ott

# Vestin Hotel, Renaissance Center, Detroit

#### **Tuberculosis: An Old Problem with New Faces**

PRESENTED BY: Michigan Thoracic Society

This course will enhance the participant's understanding of current and future issues in the prevention, control, diagnosis and management of mycobacterial diseases. Specifically, the participant will be able to express methods of prevention for tuberculosis, and describe new technologies for tuberculosis management and control.

COURSE CO-DIRECTORS: Larry Rawsthorne, MD, President, Michigan Thoracic Society and Steven Springer, Administrative Director, Michigan Thoracic Society.

PRESIDING: Marc Peters-Golden, MD, University of Michigan School of Medicine

#### **Update on Hypertension**

PRESENTED BY: Division of Nephrology, Henry Ford Hospital, Detroit

This course will focus on pathogenesis of hypertension, cellular mechanisms and genetics, and an analysis of recent data on therapy of essential hypertension. It will include a review of antihypertensive drug efficacy and quality of life.

COURSE DIRECTOR: S. Steigerwalt, MD, Acting Section Chief, Hypertension, Henry Ford Hospital, Detroit

PRESIDING: Doctor Steigerwalt

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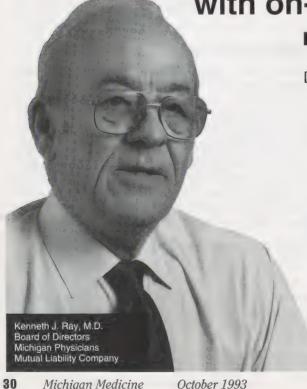
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# All courses offer 3 hours of Category I CME Credit

#### **Wednesday Morning, November 10**

All courses run from 8:30 a.m. to Noon with a half-hour break

#### No Charge for this "Early Bird" Plenary Session

Complimentary Coffee Available at 7:00 a.m. MSMS Cafe Open for Refreshments at 7:00 a.m.

#### "The Genetics of Breast Cancer"

Barbara L. Weber, MD, Assistant Professor of Medicine and Director of Breast Oncology, University of Michigan Medical School, Ann Arbor,

This one-hour plenary session will feature an overview of the latest information regarding genetic studies in the prevention, diagnosis and management of breast cancer. Doctor Weber will outline research being conducted at the University of Michigan to identify genes that may be responsible for inherited forms of breast cancer, efforts to identify family members at high risk for developing breast cancer, and the implication for predictive testing and novel diagnostic and therapeutic strategies in the future.

Approved for 1 hour of Category I CME Credit

#### Anaphylaxis: Pathophysiology, Etiology, Clinical Characteristics and Treatment

PRESENTED BY: Departments of Medicine and Pediatrics, Wayne State University School of Medicine and Detroit Medical Center

This course will provide current information on the pathophysiology, etiology, clinical characteristics, and the treatment of anaphylaxis. Latex and iodinated dye sensitivity also will be discussed in detail.

COURSE DIRECTOR: Michael R. Simon, MD, FACP, Training Program Director, Allergy and Immunology, Detroit Medical Center; Associate Professor, Departments of Medicine and Pediatrics, Wayne State University School of Medicine.

PRESIDING: Doctor Simon

#### **Basic Cardiac Life Support**

PRESENTED BY: St. Lawrence Hospital and Michigan College of Emergency Physicians

This course will include lectures and practical situations for teaching Basic Cardiac Life Support according to the American Heart Association Guidelines. The session includes hands-on teaching of cardiopulmonary resuscitation, obstructed airways in unconscious and conscious victims, including infants and CPR. A BCLS card or Heart Saver card will be presented upon completion.

COURSE DIRECTOR: Robert K. Orr, Jr., DO, Vice Chief, Department of Emergency Medicine, St. Lawrence Hospital, Lansing

PRESIDING: Doctor Orr

#### Clinical Problems in Fluid, Electrolyte and Acid-Base Disorders

PRESENTED BY: Division of Nephrology/Hypertension, Henry Ford Hospital, Detroit

Case vignettes will be selected and presented to illustrate common problems in disorders of sodium, potassium, magnesium and acid-base balance. Practical aspects of the associated pathophysiology will be stressed and their application to diagnosis and therapy will be discussed in depth.

COURSE DIRECTOR: Robert G. Narins, MD, Director, Nephrology/Hypertension Division, Henry Ford Hospital, Detroit

PRESIDING: Doctor Narins

#### **Computers In Medicine (Basic Level)**

\* This Limited Attendance Workshop is a smaller, handson program with a \$75.00 course fee.

PRESENTED BY: Department of Medical Education, Oakwood Hospital, Dearborn

This course will introduce the practicing physician to the power of computers in medicine. Basic computer skills, including principles of DOS and word processing will be presented as will the use of literature search and differential diagnosis programs. Time will be provided for the participating physicians to explore these programs in a live computer laboratory.

COURSE DIRECTOR: Nicholas Lekas, MD, FACP, Director,

31

# Westin Hotel, Renaissance Center, Detroit

Internal Medicine Residency, and Department of Medical Education, Oakwood Hospital, Dearborn

PRESIDING: Doctor Lekas

#### **Improving Physician/Patient Communication Skills**

PRESENTED BY: MSMS Committee on Concerns of Women Physicians

This course is designed to facilitate interaction between physicians and patients, as well as in professional relationships. The objective is to emphasize sensitivity to the variety of characteristics physicians encounter in their professional environment and improve patient compliance, by using case studies and small group interaction.

COURSE DIRECTOR: Tama D. Abel, MD, Chair, MSMS Committee on Concerns of Women Physicians

PRESIDING: Doctor Abel

### Office Management of Common Foot and Ankle Disorders

PRESENTED BY: Michigan Orthopaedic Society

This course will provide basic knowledge for the treatment of plantar fascitis, sprained ankles and feet, corns, callouses, nails, and warts, with special emphasis on posterior tibial tendon dysfunction. Padding and appliances will be discussed.

COURSE DIRECTOR: Arthur Manoli, II, MD, Professor, Orthopaedic Surgery, Wayne State University School of Medicine, Michigan Orthopaedic Society

PRESIDING: Doctor Manoli

#### **Primary Care After 50**

PRESENTED BY: Department of Obstetrics and Gynecology and Reproductive Endocrinology, Providence Hospital, Southfield

This course will include a brief discussion of menopausal physiology and the advantages and disadvantages of hormone replacement therapy as prophylaxis for cardiovascular disease and osteoporosis. Cancer detection will be addressed for both men and women in terms of what to look for and how best to test in terms of cost effectiveness and accuracy. Discussion of nutrition and diet as they relate to aging and to cancer prevention will be included.

COURSE DIRECTOR: Paul T. Schnatz, MD, Obstetrics and Gynecology Education Coordinator, Obstetrics and Gynecology Reproductive Endocrinology, Providence Hospital, Southfield

PRESIDING: Doctor Schnatz

### Progress in Neurosurgery for the 21st Century (Part 1)

PRESENTED BY: Department of Neurological Surgery, Henry Ford Hospital, Detroit

This first session in a two-part series on Neurosurgery will address chemotherapy in Neuro-Oncology, as well as surgical, gene therapy and other brain tumor treatments. Courses can be taken together or separately.

COURSE DIRECTOR: Mark L. Rosenblum, MD, Chairman, Department of Neurological Surgery, Henry Ford Hospital, Detroit; Director, Midwest Neuro-oncology Center, Henry Ford Health Sciences Center, Detroit

PRESIDING: Doctor Rosenblum

#### **Update on the Treatment of BPH**

PRESENTED BY: Department of Urology, Henry Ford Hospital, Detroit

With the recent advances in the treatment of BPH, this course will include a complete review of medical management (blocking agents, 5-alpha reductase inhibitors), balloon dilation, urethral coils, laser, hyperthermia, and other options including the standard surgical treatment.

COURSE DIRECTOR: Riad N. Farah, MD, Vice-Chairman, Department of Urology, Henry Ford Hospital, Detroit

PRESIDING: Doctor Farah

#### Wednesday Afternoon, November 10

All courses run from 1:30 p.m. to 5:00 with a half-hour break

#### **Computers In Medicine (Advanced Level)**

\* This Limited Attendance Workshop is a smaller, handson program with a \$75.00 course fee.

PRESENTED BY: Department of Medical Education, Oakwood Hospital, Dearborn

Physicians with knowledge of and skills in word processing may participate in this course which will review the following concepts: modeming and electronic mail, the practical use of reference manager programs, and the paperless medical record. Hand-held computer technology will also be presented.

COURSE DIRECTOR: Nicholas Lekas, MD, FACP, Director, Internal Medicine Residency, Oakwood Hospital Department of Medical Education, Dearborn

PRESIDING: Doctor Lekas

#### **Contraception: For Women of All Ages**

PRESENTED BY: Department of Obstetrics and Gynecology, Wayne State University School of Medicine

A series of lectures on new developments in the field of steroidal contraceptive, both oral and long-acting parenteral formulations, contraceptive needs of perimenopausal women, and clinical application of newly-developed IUDs will be presented.

COURSE DIRECTOR: Kamran S. Moghissi, MD, Professor Emeritus, Department of Obstetrics and Gynecology, Wayne State University School of Medicine

PRESIDING: Doctor Moghissi

#### **Dermatological Diagnosis and Therapy**

PRESENTED BY: Michigan Dermatological Society

This course will instruct and review for primary care, consulting physicians and dermatologists both time-honored and new therapeutic modalities. In addition, an update on basic surgical therapy tips will be rendered.

COURSE DIRECTOR: L. Boyd Savoy, MD, Chief, Dermatology Service, VA Hospital, Allen Park

PRESIDING: Doctor Savoy

### Evaluation and Management of Pediatric and Adolescent Spinal Deformities

PRESENTED BY: Department of Orthopaedic Surgery, Children's Hospital of Michigan, Detroit

This course is designed to give primary care specialists an understanding of the etiology, natural history, diagnosis, treatment and indications for referral and consultations for various childhood and adolescent spinal deformities includ-

ing scoliosis, Scheuermann's kyphosis, juvenile round back, Spondylolysis and spondylolisthesis. This course will include specific case presentations.

COURSE DIRECTOR: Carl L. Stanitski, MD, Chief, Department of Orthopaedic Surgery, Children's Hospital of Michigan, Detroit

PRESIDING: Doctor Stanitski

#### **Management of Asthma Problems**

PRESENTED BY: Michigan Allergy Society

This course will instruct primary and consulting physicians in several important areas concerning the management of asthma. The relative values and risks of different modes of treatment will be discussed along with the special problem of diagnosing occupational asthma. The information presented will allow physicians to improve the care they provide for patients with asthma.

COURSE DIRECTOR: Dennis R. Ownby, MD, President Elect, Michigan Allergy Society, Henry Ford Hospital, Detroit

PRESIDING: Doctor Ownby

### Management of Neoplasms of Colorectum: Strategies for the 90's

PRESENTED BY: Michigan Society of Colon and Rectal Surgeons

This course will provide the latest information regarding the management of colorectal cancers for several medical specialties; familiarizing physicians with epidemiologic data and the understanding of the current concept of carcinogenesis of these neoplasms. Early detection, effective screening tests, and controversies in the management of rectal cancer will be discussed.

COURSE DIRECTOR: Chairat P. Chomchai, MD, FRCS(C), FACS, President, Michigan Society of Colon and Rectal Surgeons

PRESIDING: Doctor Chomchai

#### **Management of Urinary Incontinence**

PRESENTED BY: Wayne State University School of Medicine and Hutzel Hospital, Detroit

# November 9, 10 & 11, 1993, Westin Hotel, Renaissance Center, Detroit

#### **Primary Care for People with Disabilities**

PRESENTED BY: Michigan Academy of Physical Medicine and Rehabilitation

Specific issues and problems regarding the provision of primary care to people with disabilities will be discussed. A model for a primary clinic for people with disabilities, sponsored by Michigan Medicaid, will be presented with preliminary data regarding the demographics and effectiveness for the clients served by the clinic.

COURSE DIRECTOR: Steven R. Hinderer, MD. Chairman of Education and Publicity, Michigan Academy of Physical Medicine and Rehabilitation

PRESIDING: Doctor Hinderer

#### **Progress in Neurosurgery for the 21st Century** (Part 2)

PRESENTED BY: Department of Neurological Surgery. Henry Ford Hospital, Detroit

This course will continue the morning's discussion of Neurosurgery in the 21st Century, focusing on the surgical and non-surgical management of epilepsy, movement disorders, pain, AVMS and aneurysms, and stroke. Courses can be taken together, or separately.

COURSE DIRECTOR: Mark L. Rosenblum, MD, Chairman, Department of Neurological Surgery, Henry Ford Hospital, Detroit; Director, Midwest Neuro-oncology Center, Henry Ford Health Sciences Center, Detroit

PRESIDING: Doctor Rosenblum

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# November 9, 10 & 11, 1993, Westin Hotel, Renaissance Center, Detroit

## **Thursday Morning, November 11**

All courses run from 8:30 a.m. to Noon with a half-hour break

No Charge for this "Early Bird" Plenary Session Complimentary Coffee Available at 7:00 a.m. MSMS Cafe Open for Refreshments at 7:00 a.m.

## "The Evaluation and Management of Prostate Cancer"

Richard Reinhard, MD, Senior Staff, Department of Urology, Henry Ford Hospital, Detroit

This early-morning session will provide physicians with up-to-date information regarding the evaluation and management of prostate cancer. The presentation will include the latest information on prostate specific antigen (PSA) and other screening and diagnostic procedures.

Approved for 1 hour of Category I CME Credit

## A Short Course in Vascular Surgery

PRESENTED BY: American College of Surgeons, Michigan Chapter

This course will include a discussion on the evaluation and management of the painful ischemic leg, abdominal aortic aneurysm, and carotid artery stenosis, as well as surveillance of an arterial graft and prevention of deep vein thrombosis.

COURSE CO-DIRECTORS: Krishna K. Sawhney, MD, FACS, Clinical Professor, Department of Surgery, Wayne State University School of Medicine; and Michael Dahn, MD, Assistant Professor, Wayne State University School of Medicine and Chief of Vascular Surgery, VA, Allen Park

PRESIDING: Doctors Sawhney and Dahn

## **Basic Cardiac Life Support**

PRESENTED BY: St. Lawrence Hospital and Michigan College of Emergency Physicians

This course will include lectures and practical situations for teaching Basic Cardiac Life Support according to the American Heart Association guidelines. The session includes hands-on teaching of cardiopulmonary resuscitation, obstructed airways in unconscious and conscious victims, including infants, and CPR. A BCLS card or Heart Saver Card will be presented upon completion.

COURSE DIRECTOR: Robert K. Orr, Jr., DO, Vice Chief, Department of Emergency Medicine, St. Lawrence Hospital, Lansing

PRESIDING: Doctor Orr

## **Current Management of Sinusitis**

PRESENTED BY: Michigan Otolaryngological Society

This course will focus on the evaluation and management of pediatric and adult sinus disease. Topics will include: 1) anatomy and physiology of sinusitis, 2) diagnosis of acute and chronic sinusitis, 3) medical management of sinusitis, 4) changing bacteriology and antimicrobials, 5) use of ancillary medications such as steroids, mucous thinners, and decongestants, 6) role of allergy and asthma in sinus disease, and endoscopic sinus surgery versus traditional surgical techniques. It will include a video tape with case presentation.

COURSE DIRECTOR: Steven C. Marks, MD, Assistant Professor, Department of Otolaryngology, Wayne State University School of Medicine and Samuel Mickelson, MD, MOS Council Member, Residency Training Program Director, Henry Ford Hospital, Detroit

PRESIDING: Doctors Marks and Mickelson

## Evaluation and Treatment of Arthritic Disorders of the Shoulder and Elbow

PRESENTED BY: Department of Orthopaedic Surgery, Wayne State University School of Medicine

This course will provide practical information to primary and consulting physicians concerning the diagnosis, patient selection and treatment options for arthritic conditions of the shoulder and elbow. Emphasis will be on the matching of various non-operative and surgical options to careful patient selection, and the evolution and success of shoulder and elbow arthroplasty and rehabilitation in treating these disorders, through the use of specific case presentations and video.

COURSE DIRECTOR: Steve A. Petersen, MD, Assistant Professor, Department of Orthopaedic Surgery, Wayne State University School of Medicine and Hutzel Hospital, Detroit

PRESIDING: Doctor Petersen



## **Fetal and Perinatal Wound Healing and Surgery**

PRESENTED BY: Michigan Academy of Plastic Surgery

Plastic surgeons are consulted for repair of congenital deformities, especially of the face and hands. A relatively recent accumulation of information about fetal wound healing and surgery will be reviewed in this course with correlation with our present and potential future practices.

COURSE DIRECTOR: Donald M. Ditmars, Jr., MD, Henry Ford Hospital, Detroit

PRESIDING: Doctor Ditmars

## Newer Guidelines for Therapy in Cardiovascular Medicine

PRESENTED BY: Department of Internal Medicine, University of Michigan Medical School and University of Michigan College of Pharmacy

This course through lecture and case presentations will review newer guidelines for cardiovascular therapy including the treatment of hyperlipidemia and congestive heart failure. The role, rationale, and controversies of drug therapy will be emphasized.

COURSE DIRECTOR: Barry E. Bleske, PharmD, University of Michigan College of Pharmacy, and Melvyn Rubenfire, MD, Dept. of Internal Medicine, University of Michigan Medical School

PRESIDING: Doctor Bleske and Rubenfire

## **Respiratory Update for the Practicing Physician**

PRESENTED BY: Section of Pulmonary and Critical Care, Sinai Hospital, Detroit

This course will familiarize and update physicians with the epidemiology, early recognition, pathogenesis and treatment modalities of respiratory infections, hospital acquired pneumonia and sleep apnea.

COURSE DIRECTOR: Bohdan Pichurko, MD, Chief, Section of Pulmonary and Critical Care, Sinai Hospital, Detroit, Associate Professor, Wayne State University School of Medicine

PRESIDING: Doctor Pichurko

## The Peptic Ulcer: A Changing Disease

PRESENTED BY: Division of Gastroenterology, Henry Ford Hospital, Detroit

This course will provide 1) a review of the pathogenesis of peptic ulcer disease, including a critical evaluation of the role of H. pylori infection, 2) an approach to the evaluation of the patient with ulcer symptoms, 3) a review of the medical therapies for ulcer disease, and it's complications, and 4) a surgeon's perspective of ulcer disease surgery.

COURSE DIRECTOR: Ronald Fogel, MD, Henry Ford Hospital, Detroit

PRESIDING: Doctor Fogel

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# November 9, 10 & 11, 1993, Westin Hotel, Renaissance Center, Detroit

## **Thursday Afternoon, November 11**

All courses run from 1:30 p.m. to 5:00 p.m. with a half-hour break

## A Multidisciplinary Approach to Management of the Obese Patient

PRESENTED BY: Department of Internal Medicine, University of Michigan Medical School

This course will review current recommendations for safe weight loss, strategies for developing an effective weight loss program and the place of nutritional, exercise and behavioral therapies. Existing pharmacological agents and developing new compounds for the pharmacological management of obesity will be discussed.

COURSE DIRECTOR: David E. Schteingart, MD, Professor of Internal Medicine, University of Michigan Medical School

PRESIDING: Doctor Schteingart

## **Common Problems in Nephrology**

PRESENTED BY: Division of Nephrology, Harper Hospital, Detroit

This course will provide the practicing physician with an overview of current concepts in the pathogenesis and treatment of common nephrologic problems, 1) the kidney in diabetes, 2) proteinuria - when to call the nephrologist, 3) nephrolithiasis - a practical approach to diagnosis and newer methods of management, and 4) renal transplant - where we are now.

COURSE DIRECTOR: Stephen Migdal, MD, Professor, Department of Medicine, Wayne State University School of Medicine and Harper Hospital, Detroit

PRESIDING: Doctor Migdal

## Diagnosis and Management of Pulmonary Embolism

PRESENTED BY: Michigan College of Nuclear Medicine Physicians

Using a case management approach, this course will cover the cost-effective diagnosis and therapy of pulmonary embolism. At its conclusion, the attendee will be able to determine which patients are likely to have PE, which tests to order to prove or disprove the PE diagnosis, and what therapy to institute.

COURSE DIRECTOR: John E. Freitas, MD, Director,

Nuclear Medicine, Radiology Department, St. Joseph Mercy Hospital, Ann Arbor

PRESIDING: Doctor Freitas

## Diagnosis and Non-Operative Treatment of Lumbar Radiculopathies

PRESENTED BY: Department of Physical Medicine and Rehabilitation, Sinai Hospital, Detroit

The presenters will discuss symptoms and signs to diagnose lumbar radiculopathy, the importance of various examinations including MRIs, CT scans and electromyography, and the importance and follow-up of non-operative care. Select patients who have improved with non-operative therapy will be present to help emphasize the severity of their symptoms and level of improvement.

COURSE DIRECTOR: Joseph C. Honet, MD, Chairman, Department of Physical Medicine and Rehabilitation, Sinai Hospital, Detroit

PRESIDING: Doctor Honet

## **Environmental Medicine for the Practicing Physician**

PRESENTED BY: Michigan Occupational and Environmental Medical Association

This course is designed to provide the practicing physician with a means of assessing environmental health hazards in terms of risk, and to offer guidelines for addressing major health concerns associated with exposures to physical and chemical agents both within the workplace and the community.

COURSE DIRECTOR: John H. Triebwasser, MD, President-Elect, Michigan Occupational and Environmental Medical Association, Dearborn

PRESIDING: Doctor Triebwasser

## Nutritional Treatment for Cardiovascular Risk Factor Reduction: From Theory to Practice

PRESENTED BY: MedSport, University of Michigan Medical Center

At the completion of this course, the participant will be able to: (1) Discuss the role of kilocalories, total fat, saturated fat, trans fatty acids on cardiovascular disease risk; (2) Implement the NCEP ATP II nutritional guidelines into food choices; (3) Recognize the potential of diet therapy in

# All courses offer 3 hours of Category I CME Credit

various types of dyslipidemias including hypercholesterolemia, hypertri-glyceridemia, and diabetic dyslipidemia; (4) Describe the effectiveness of diet therapy in enhancing the drug therapy for lipid management; (5) Recognize the potential role of weight management in cardiovascular risk reduction; (6) List the characteristics of health long term weight management approaches including the "no diet" approach; and (7) List counseling techniques to enhance patient motivation and to facilitate behavior change.

COURSE CO-DIRECTORS: Melvyn Rubenfire, MD, Professor of Internal Medicine, Division of Cardiology, University of Michigan Medical Center, MedSport and Kathy Rhodes, PhD, RD, Cardiovascular Nutritionist, University of Michigan Medical Center, MedSport

PRESIDING: Doctors Rubenfire and Rhodes

## Psychiatric Side Effects of Medical Drugs/Medical Effects of Psychiatric Drugs

PRESENTED BY: Michigan Psychiatric Society

This course will acquaint the clinician with medical side effects of psychopharmacologic agents, psychiatric behavioral side effects of drugs typically used in medical and surgical situations, medical disorders which present with psychiatric symptoms, and psychiatric disorders which present with medical complaints.

COURSE DIRECTOR: Oliver Cameron, MD, PhD, Professor, University of Michigan Medical School

PRESIDING: Doctor Cameron

## **Primary Care and the Educational System**

PRESENTED BY: Department of Pediatrics and Human Development, Michigan State University College of Human Medicine

This course will present models of how primary care physicians have interacted with the public school system to address the health care needs of children and youth in the educational setting. Topics will include attention deficit hyperactivity disorder, asthma, diabetes, the medically fragile child, and the multiply handicapped child.

COURSE DIRECTOR: Miriam S. Daly, MD, Private Practice, Albion, Michigan Academy of Family Physicians

PRESIDING: Marsha D. Rappley, MD, Assistant Professor, Pediatrics and Human Development, Michigan State University College of Human Medicine; Director, Collaborative Developmental Clinic

## **Update in Plastic Surgery Procedures**

PRESENTED BY: Michigan Academy of Plastic Surgery

In the last 20 years, the specialty of plastic surgery has expanded to encompass a diverse variety of disciplines including microsurgery, clinical oncology, burn reconstruction and craniofacial surgery. This course offers a sampling of this vast array of clinical research topics.

COURSE DIRECTOR: Edwin G. Wilkins, MD, Assistant Professor, University of Michigan Medical School

PRESIDING: Doctor Wilkins

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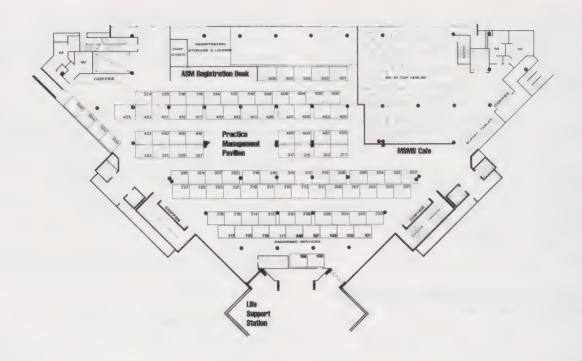
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# MSMS Annual Scientific Meeting, November 9, 10 & 11, 1993



## **Exhibit Hall Hours**

## Monday, November 8

12:00 Noon - 5:00 p.m. Exhibit Set-Up

## Tuesday, November 9

**7:00 a.m. - 6:00 p.m.** Registration and Exhibits Open to Physicians and Guests. Complimentary Exhibit Hall Passes Available

**8:00 a.m. - 9:30 a.m.** Exhibitor "Welcome" Breakfast and presentation on "The Dynamics of Medical Show Exhibiting," presented by Susan Friedmann of Diadem Communications, Cincinnati, Ohio.

## Wednesday, November 10

**7:00 a.m. - 6:00 p.m.** Registration and Exhibits Open to Physicians and Guests. Complimentary Exhibit Hall Passes Available.

## Thursday, November 11

**7:00 a.m. - 3:45 p.m.** Registration and Exhibits Open to Physicians and Guests. Complimentary Exhibit Hall Passes Available.

3:45 p.m. - 5:00 p.m. Exhibit Move-Out

### Coffee

Coffee will be available during the hours of the Exhibit Hall, compliments of MSMS.

During the "early bird" plenary sessions, coffee will also be available in the back of the room.

### MSMS Cafe

In addition to free coffee provided by MSMS, several vendors will offer morning refreshments, a variety of lunch time selections and afternoon beverages and refreshments for purchase. You can choose what you want and determine how much you want to spend, then relax in the convenient dining area provided in the MSMS exhibit hall.

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- 111 Blue Cross Blue Shield of Michigan \*
- 113 Blue Cross Blue Shield of Michigan \*
- 115 Blue Cross Blue Shield of Michigan \*
- 117 Blue Cross Blue Shield of Michigan \*
- 200 Bell Atlantic TriCon Leasing \*
- 201 Bennethum Computer Systems, Inc.
- **203** Physicians Recovery Network
- 204 I.C. System\*
- 205 Education Disability Determination Service
- 208 Stratton, Cheeseman & Walsh, Inc. \*
- 215 Detroit Riverview Hospital

- 216 Association Members Retirement Program \*
- 218 Select Communications \*
- 223 Colonial Valley Software
- 225 Medical Management Systems of MI
- 227 Metro Rehab Services, Inc.
- 300 Wyeth-Averst Laboratories
- 302 Wyeth-Ayerst Laboratories
- 304 Genius Solutions, Inc.
- **306** Health Quest Infusion Therapy
- 311 Professional Asset Management, Inc.
- 314 John Hancock
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- 320 Butterworth Hospital
- 327 Professional Alliance, Inc.
- 329 Tri-County Collection Bureau, Inc.
- 331 US Army Medical Department
- 333 Smith Kline Beecham Pharmaceuticals
- 400 Ameritech Small Business Markets
- 401 CompHealth
- 402 Ameritech Cellular

- 403 Searle Pharmaceuticals
- **404** Michigan Practice Brokerage
- Firestone X-Ray Corporation
- 418 Nationwide Collection Agencies
- 420 HealthCare Communications
- 422 Selectcare
- **423** Fisons Pharmaceuticals
- **425** Physicians Insurance Company of
- **500** Medical Automation Inc.
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- **520** Metrostaff Health Care Services
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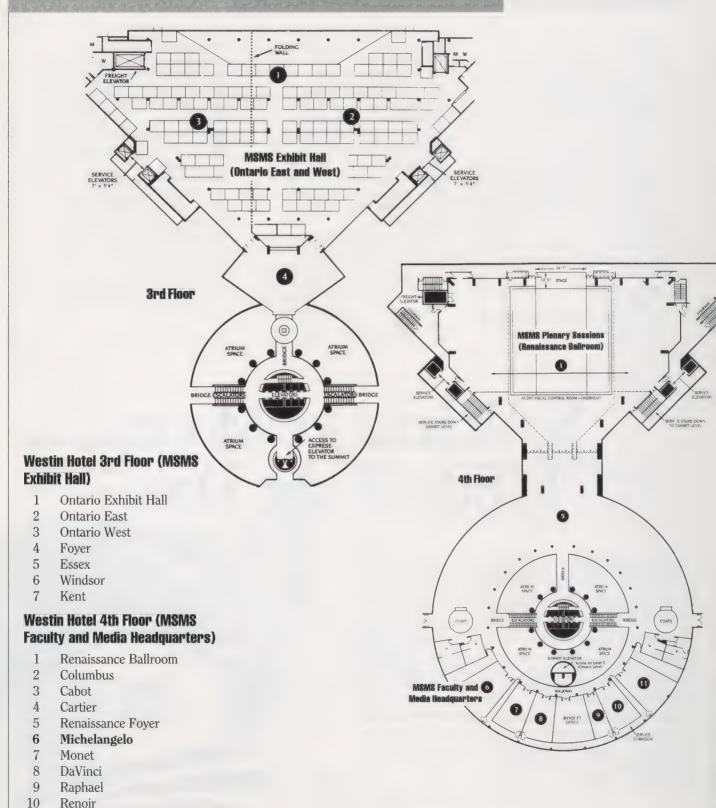






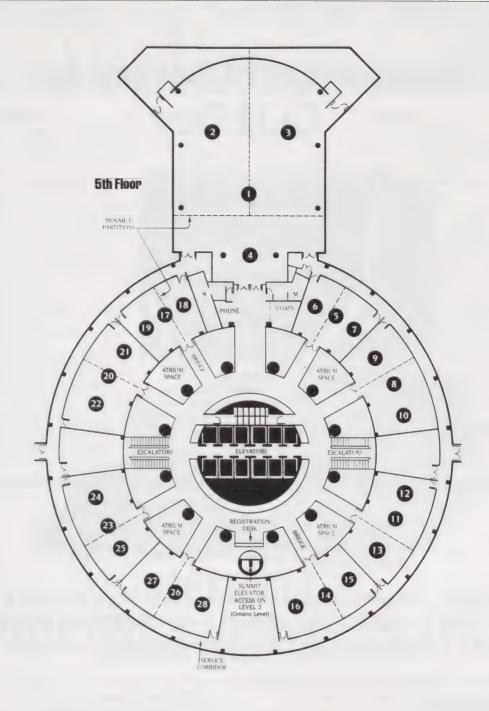


# November 9, 10 & 11, 1993, Westin Hotel, Renaissance Center, Detroit



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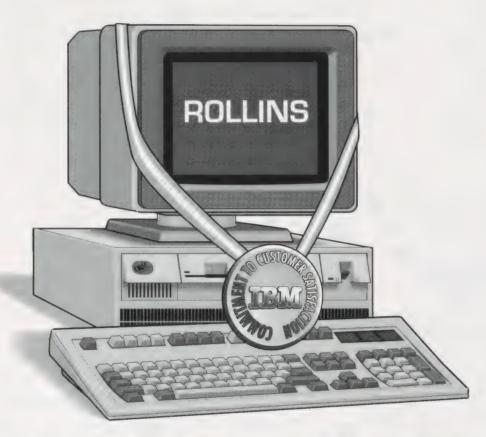
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| 3  | Mackinac East     | 13 | LaSalle B  | 22 | Nicolet B |
| 4  | Mackinac Foyer    | 14 | Cadillac   | 23 | Brule     |
| 5  | Joliet            | 15 | Cadillac A | 24 | Brule A   |
| 6  | Joliet A          | 16 | Cadillac B | 25 | Brule B   |
| 7  | Joliet B          | 17 | Duluth     | 26 | Richard   |
| 8  | Marquette         | 18 | Duluth A   | 27 | Richard A |
| 9  | Marquette A       | 19 | Duluth B   | 28 | Richard B |
| 10 | Marquette B       |    |            |    |           |

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# November 9, 10 & 11, 1993, Westin Hotel, Renaissance Center, Detroit

## **Specialty Societies**

American College of Surgeons, Michigan Chapter American Diabetes Association, Michigan Affiliate Michigan Academy of Physical Medicine and

Michigan Academy of Plastic Surgery

Michigan Allergy Society

Michigan Alzheimer's Disease Research Center, Alzheimer's Association, Michigan Council

Michigan College of Emergency Physicians

Michigan College of Nuclear Medicine Physicians

Michigan Dermatological Society

Michigan Occupational and Environmental Medical Association

Michigan Orthopaedic Society

Michigan Otolaryngological Society

Michigan Psychiatric Society

Michigan Society of Colon and Rectal Surgeons

Michigan Thoracic Society

MSMS AIDS Provider Education Project

MSMS Alliance

MSMS Committee on Concerns of Women **Physicians** 

MSMS Physician Organizations Committee

MSMS Task Force on Environment and Health MSMS Task Force on Physician Well-Being

Washtenaw County Medical Society

### **Medical Schools**

Michigan State University College of Human

Department of Pediatrics and Human Development

Department of Medical Ethics and Health

University of Michigan College of Pharmacy University of Michigan Medical School

MedSport

Department of Breast Oncology

Department of Internal Medicine

Department of Medicine

Pediatric Ambulatory Care

Wayne State University School of Medicine

Department of Medicine

Department of Obstetrics and Gynecology

Department of Orthopaedic Surgery

Department of Pediatrics

Department of Radiology

Division of Endocrinology

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**Detroit Medical Center** 

Children's Hospital of Michigan, Detroit

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Harper Hospital, Detroit

Division of Nephrology

Henry Ford Hospital

Department of Neurological Surgery

Department of Urology

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Division of Hypertension

Division of Nephrology

Hutzel Hospital, Detroit

Oakwood Hospital

Department of Medical Education

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# MSMS Annual Scientific Meeting, November 9, 10 & 11, 1993

## Expanded Programming For Physicians, Medical Group Managers, Medical Office Staff, and MSMS-Alliance

The MSMS Annual Scientific Meeting now includes expanded programming for physicians, nurses, medical group managers, medical assistants and other office staff, as well as members of the MSMS-Alliance.

## Tuesday, November 9

12:00 Noon - 1:30 p.m.

## MSMS/MPMLC Closed Claim Review Session - General Medicine

A round-table discussion of closed Michigan malpractice cases, structured to encourage group participation and offer possible preventive measures. 2% MPMLC premium reduction and 2 hours of Category I CME credit. \$55 per person.

### Wednesday, November 10

7:00 a.m. - 8:30 a.m.

## MSMS/MPMLC Closed Claim Review Sessions- Allergy and Dermatology

Two round-table discussions of closed Michigan malpractice cases, specialty-specific, structured to encourage group participation, offering possible preventive measures. 2% MPMLC premium reduction and 2 hours of Category I CME credit. \$55 per person. *Limited Attendance Workshop*.

## 1:30 p.m. - 5:00 p.m. Exceptional Leadership Skills

A training program to improve skills in parliamentary procedure, planning and running effective meetings, public speaking and media relations, and other important leadership issues. Appropriate for persons at all levels of leadership experience. Cost per person: \$55 MSMS, MMGMA, MSMA or MSMS-A members; \$75 non-members.

## 1:30 p.m - 5:00 p.m. MSMS/BCBSM Automated Billing Update

Representatives from Blue Cross/Blue Shield of Michigan, Medicare and Medicaid will present this hands-on program to answer your specific questions and demonstrate how to more effectively use electronic billing systems such as DENIS, Automated Response Unit, and ASSIST. Cost per person: \$55 MSMS, MMGMA, MSMA or MSMS-A members; \$75 non-members.

## Thursday, November 11 8:30 a.m. - 12:00 Noon Risk Management for the Medical Office Staff

This program will address the role of the entire medical office

staff in improving physician/patient communication and ensuring optimal patient satisfaction, including methods for maintaining accurate medical record documentation. Cost per person: \$55 MSMS, MMGMA, MSMA or MSMS-A members; \$75 non-members.

## 8:30 a.m. - 12:00 noon Practical Solutions for Healthier Eating

A"light hearted" program that will outline dietary guidelines and provide practical solutions for following a healthy diet, including helpful resource materials, suggestions for reading food labels, a simple food demonstration and tasty, low fat food samples. Cost per person: \$55 MSMS, MMGMA, MSMA or MSMS-A members; \$75 non-members.

In addition to the specific programming above, the full array of clinical courses and complimentary admission to the exhibit hall and practice management pavilion are available to all health care providers. See full ASM program schedule for further information.

## ASM Expanded Programming

Check your program choice(s):

Closed Claim Review - General Medicine
Closed Claim Review - Allergy

Closed Claim Review - Dermatology

□ Exceptional Leadership Skills
 □ MSMS/ BCBSM Automated Billing Update
 □ Risk Management for the Medical Office Staff

☐ Practical Solutions for Healthier Eating

PLUS, \$20.00 One-time Registration Fee (Includes registration, handouts, parking, etc.)

MAIL WITH PAYMENT TO: Michigan State Medical Society 120 W. Saginaw, P.O. Box 950 East Lansing, MI 48826-0950

| PAYMENT                             | PLEASE TYPE OR PRIN       | T CLEARLY.       |
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| ☐ Member Rate ☐ Non-Member Rate     | Name of Attendee (to regi | ster more than o |
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| Card No.                            | Specialty                 |                  |
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Authorized Signature

## Annual Scientific Meeting Registration Form

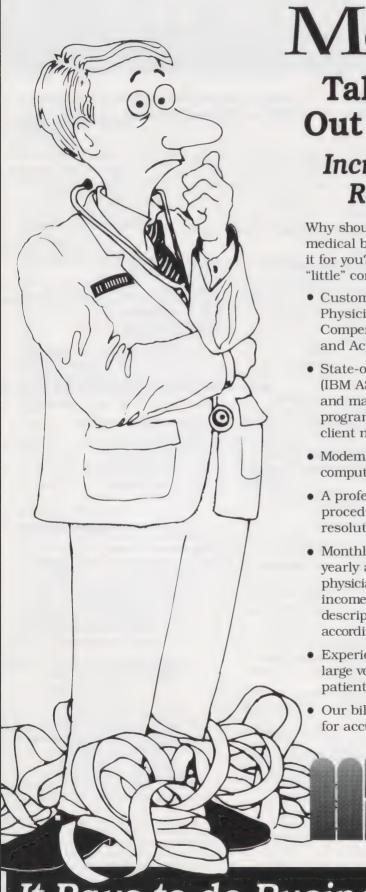
1993 MSMS Annual Scientific Meeting, November 9, 10 & 11, Wastin Hotel, Renaissance Center, Detroit

| Please print  |   |  |  |  |
|---|---|--|--|--|
| Name  |   |  |  |  |
| (first) (initial)  Street   | (last)  | (title)  |  | Adopt-a-Doctor Discount*   |
| City  | State   | Zin  |  | Take \$20 off your registration tot if you bring a physician who has   |
| County Phone (  |   | Previous attendee?   |  | never attended (or if you have never attended) an MSMS Annua   |
|   |   |  | L ies L No   | Scientific Meeting.  |
| MSMS Member: ☐ Yes ☐ No ☐ Resident ☐ S  |   |  |  | Your "adopted doctor" is:  |
| CHOOSING YOUR COURSES: Please indicas smaller, hands-on courses with a higher regis   |   | d choice. Limited Attendance   | Workshops are  |  |
| Tuesday Morning, November 9   | Wednesday Afterno   |  | Your Payment   |  |
| Special "Early Bird" Plenary Session on "Health System Reform" (7:15 - 8:15 a.m., No Course Fee)  (8:30 a.m. to Noon, including break)  Basic Cardiac Life Support  Current Issues in Environmental Health  50 Ways to Relieve Physician Stress and Create a Healthier Practice  Health Care Reform: What Are the Implications for My Patients and for the Future of My Medical Practice?  HIV: The Debate on Written Informed Consent Requirements  Primary Care of Injured Athletes  Radiology for Clinicians  Recognizing and Diffusing the Potentially Violent Patient  What's New About Alzheimer's Disease?  Tuesday Afternoon, November 9  (1:30 p.m. to 5:00 p.m., including break)  Common Abdominal Problems in Children  Computers in Medicine (Basic Level) Limited Attendance Workshop  Domestic Violence - The Sequel  Life Threatening Adverse Drug Reactions  Management of Diabetes Mellitus: Impact of the DCCT  Rehabilitation of the Injured Athlete  Tuberculosis: An Old Problem with New Faces  Update on Hypertension | Computers in Medited Attendance I Contraception for Dermatologic Diag Evaluation and M Adolescent Spinal Management of As Management of Uprimary Care for I Progress in Neuro (Part II)  Thursday Morning,  "Early Bird" Plenacer" (7:15 a.m. to (8:30 a.m. to Noon,  A Short Course in Basic Cardiac Life Current Managem Evaluation and Toders of the Should Fetal and Perinatagery  Newer Guidelines lar Surgery | Women of All Ages gnosis and Therapy anagement of Pediatric and Deformities sthma Problems Neoplasms of Colorectum: 90's inary Incontinence People with Disabilities surgery for the 21st Century  November 11 ry Session on "Prostate Can- 8:15 a.m., No Course Fee) including break) Vascular Surgery Support ent of Sinusitis reatment of Arthritic Disor- der and Elbow al Wound Healing and Sur- for Therapy in Cardiovascu- e for the Practicing Physician | Residents: \$25 per Non-Members: \$75 Nurses: \$55 per co Students: No Cour Limited Attendance **NOTE: Each att registration fee. handouts, coffee, p Multiply total num appropriate fee: One-time Registra x \$55 (mei x \$55 (mei x \$75 (nor x \$75 (nor x \$75 (Lim Adopt-a-Doctor Di Special Event Tick "Reclaimin Dinner & Prog "Night of I Dinner Recepti MDPAC | ith "retired status": \$25 per course course per course urse see Fee e Workshops: \$75 per course tendee must pay a \$20 one-time Includes registration materials, parking, etc.  ber of half-day courses by  tion Fee** \$20.00 mbers) + \$ red & residents) + \$ red & residents) + \$ rests) + \$ |
| Wednesday Morning, November 10  |   | .m., including break)  |  | er Attendees \$40 ea. \$<br>icket Only: \$15   |
| ☐ "Early Bird" Plenary Session on "Breast Cancer" (7:15 - 8:15 a.m., No Course Fee)   | of the Obese Patie  |  |  | hysicians Luncheon Tickets \$18 each+ \$   |
| (8:30 a.m. to Noon, including break)  Anaphylaxis: Pathophysiology, Etiology, Clini-  |   | s in Nephrology<br>nagement of Pulmonary Em-   |  | TOTAL = \$   |
| cal Characteristics and Treatment  Basic Cardiac Life Support  Clinical Problems in Fluid, Electrolyte and Acid-  | Lumbar Radiculor  |  |  | able to Michigan State Medical<br>SMS, 120 W. Saginaw, P.O. Box  |
| Base Disorders  Computers in Medicine (Basic Level) Limited  Attendance Workshop  Improving Physician/Patient Communication   | sician  | dicine for the Practicing Phy-<br>nent for Cardiovascular Risk   | ☐ Check Enclosed<br>Charge to: ☐ Visa  | ☐ Please Invoice   |
| Skills  Office Management of Common Foot and Ankle  | ☐ Psychiatric Side E<br>Medical Effects of  | ffects of Medical Drugs and<br>Psychiatric Drugs   | Card #   | Exp. Date  |
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| ☐ Primary Care After 50 ☐ Progress in Neurosurgery for the 21st Century (Part I) ☐ Update on The Treatment of BPH   | Update in Plastic 9   | burgery Procedures   | nization accredited<br>Accreditation, certification for a maximum<br>toward the requirem   | tee on CME Programming, an orga-<br>by the MSMS Committee on CME<br>fies that this activity meets the crite-<br>n of 20 credit hours in Category<br>tents for Michigan relicensure and of<br>Ignition Award of the AMA, provided   |

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## **MSMS-Alliance Targets Today for Tomorrow**



By Jean Howard

arget Today for Tomorrow" is the membership theme for MSMS-A for this year. The newlyrenamed Medical Society Alliance is ready to move forward together with the Michigan State Medical Society to meet the challenges that medicine faces in the future.

We must remember that membership is the foundation of our organizations. We are looking at unprecedented changes in health care in the 1990s. In order to make sure that access to health care and quality of health care are at the top of these changes, we must join the Alliance or Society at all levels. There is strength in numbers and working together, we can make a difference.

We are a natural coalition! Medical Society members and physicians want to cultivate and improve relationships in the communities and with their colleagues. Medical Alliance members have as their objec-

tive the best interests of the medical profession. The Alliance can be a forum for spouses to learn about the medical profession and its related problems. Alliance members can be another voice in the legislative arena, as just witnessed in the recent tort reform legislation.

### Cooperation key

With the national emphasis on health care reform, it will be of mutual benefit to find ways to cooperate more closely. Individual society members can lend expertise to Alliance health programs and projects as advisors or participants.

The Medical Society benefits by having a resource of people power. experienced managers, and program planners with broad community contacts. Alliance members are great public relations experts who can deliver timely health education messages and be an integral part of the medical association programs.

Together, physicians and spouses can project a caring image that will strengthen community relationships and promote quality health education.

So, physicians, if there is a spouse in your house, please encourage him or her to join the Alliance and be a part of Medicine's largest support group. For Alliance

membership information, contact your county medical society alliance or myself at 516 Birchwood Avenue, Traverse City, MI 49684.

Jean Howard is MSMS-A vice president and membership chair.



With the national emphasis on health care reform. it will be of mutual benefit to find ways to cooperate more closely. Individual society members can lend expertise to Alliance health programs and projects as advisors or participants.



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## INFOCUS

## **Burton Free Clinic**

A point of light for Flint's indigent population

By Helen Fordham



Doctor Nagaraju, right, received a Community Service Award from then MSMS President Robert D. Burton, MD, right, at the 1992 MSMS House of Delegates meeting. The award was given in recognition of his efforts to establish the Burton Free Clinic.

t was 5:30 p.m. and the clinic was crowded. More than 40 people in need of medical attention were packed into the tiny waiting room or spilled onto the pavement outside. "This is usual," says volunteer Jan Hendricks. Often patients start getting here between 3:00 p.m. and 4:30 p.m., she adds, and they come from as far away as Lapeer.

Located among boarded up shops and unoccupied businesses in Flint, the Burton Free Clinic sees only a fraction of the estimated 600,000 Michiganians without health insurance.

"We are afraid to advertise for patients," confides Flint gastroenterologist Marigowda Nagaraju, MD, founder of the clinic. His caution is understandable. Last year the clinic saw 2,000 patients, all of whom found out about the free clinic through word of mouth.

The clinic staff estimate that a further 15,000 people in

Genesee County need this service. "This is the only service of its kind in the state," explains Doctor Nagaraju.

The clinic is the brain child of Doctor Nagaraju who operated a similar service out of the Flint Hindu Temple several years ago. The services that he and his colleagues provided were so popular that he decided to make them available to the wider community.

It took three years for Doctor Nagaraju to craft a coalition of physicians, hospitals, pharmaceutical companies and the health department to make the free clinic a reality. It opened its doors September 1991. Staffed by more than 150 volunteer rotating medical professionals the clinic is open every Tuesday evening from 5 p.m. to 8 p.m.

"We see the working and employed," explains Nurse Susan Meijer who has volunteered at the clinic for the last

Continued on following page



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Continued from page 51

two years. "They just don't have insurance."

These working poor, most of whom have minimum wage jobs and cannot afford health insurance, have gained the sympathy of the volunteers. "They are dignified people," says Doctor Nagaraju. "I feel tremendous pain to see them waiting for help."

The clinic only accepts adult patients and is not equipped to deal with medical emergencies. According to Doctor Nagaraju, colds, flu, hypertension and prescription refills are the most common complaints. Yet, clinic physicians have referred patients to specialists for more serious conditions.

This is not often, however, and Meijer believes the clinic plays an important role in preventive medicine. If we did not see patients on a regular basis, she says, they could go to emergency rooms in acute stages, which is so much more expensive.

### Clinic faces some snags

The clinic is considered successful by its staff. "We hit 80 percent of our target group," says Meijer. Yet, it is not without its share of problems. Space is perhaps the most pressing difficulty. "We don't have enough space to store drug supplies," explains Doctor Nagaraju. The clinic, although well equipped by the health department, has only two examining rooms, which is not enough to accommodate the numbers of patients that come to the clinic. There are plans to obtain the use of a nearby school building, says Doctor Nagaraju, which should help alleviate the current situation. Another problem the clinic faces is getting patients hospitalized. The clinic is run on an outpatient basis and staff physicians refer approximately one patient a month to hospitals. Some area hospitals, however, are reluctant to admit patients who cannot pay, explains Doctor Nagaraju.

Attracting staff was also initially a problem, mostly because of fear of liability, says Doctor Nagaraju. "Now we have a blanket policy," he adds. "Every physician or nurse is covered." The clinic still had difficulty attracting some specialties like neurologists and psychiatrists, largely because of the amount of follow-up.

People are only asked once, however, to be a part of this program. The clinic is truly a group effort and it takes the commitment of every individual to make it work, explains Doctor Nagaraju. "We only recruit those with the heart."

Meijer, who estimates each volunteer nurses puts in between 40 and 60 hours a year acknowledges that this type of work is for some people and not for others.

### A sense of obligation

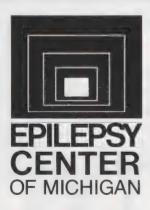
Doctor Nagaraju's own dedication to the clinic stems from his strong feeling that physicians have an obligation to their community and to less fortunate groups. "It is their duty to do this job, a duty as a citizen." he said.

He returns every year to the free clinic he helped established in India but he feels grateful to have the opportunity to assist his community in America. "Physicians volunteer an average of six to nine hours a year," he says. "It is really nothing."

Others at the clinic feel the same way. Albert C. Adam, MD, chief of staff at Genesee Memorial Hospital, has volunteered at the clinic for a year. "It is a band-aid philosophy," he explains, "but we need something." In the past Doctor Adams has volunteered his services in Haiti. "It doesn't make sense to travel 2,000 miles to help when you can help in your own community."

Helping the less fortunate is what Doctor Nagaraju and the Burton Clinic team intend to keep doing. After all, says Doctor Nagaraju, it's the least we can do.

Editor's note: If you would like further information on the Burton Free Clinic Volunteer Program please contact Doctor Nagaraju at (313) 733-3570.



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| Nasir Ahmad, MD<br>5059 E. Villa Linde #27<br>Flint, MI 48532           | ОТО    |
| Mahmoud Al-Hadidi, MD<br>2540 Coldspring<br>Bloomfield Hills, MI 48302  | PUD/IM |

Jeffrey M. Altshuler, MD

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| 6007 Miller Rd.<br>Swartz Creek, MI 48473-1514                                 | IM     | 20695 Kensington Ct. #203<br>Southfield, MI 48076                                 |
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Continued on page 57

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|   | Calories | Total<br>Fat | Saturated<br>Fatty Acids | Cholesterol |
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| Chicken Breast, skinless                      | 140      | 3.0 g        | 0.9 g                    | 72 mg       |
| Pork Tenderloin,<br>trimmed                   | 139      | 4.1 g        | 1.4 g                    | 67 mg       |
| Pork Top Loin<br>Roast (boneless),<br>trimmed | 165      | 6.1 g        | 2.2 g                    | 66 mg       |
| Center Loin Chop, trimmed                     | 172      | 6.9 g        | 2.5 g                    | 70 mg       |
| Chicken Thigh, skinless                       | 178      | 9.2 g        | 2.6 g                    | 81 mg       |

<sup>\*</sup>Table refers to 3-oz, cooked servings.

# Best of pork



## New study: Pork is now 31% leaner

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- Choose the leanest cuts. Shop for cuts with "loin" in the name.
- Trim away any visible fat.
- Keep portions moderate (about 3 oz, cooked).
- Prepare by broiling or roasting, and avoid additional fat in preparation.

1. US Dept of Agriculture. Composition of Foods: Pork Products, 1992. Agricultural handbook 8-10.

2. US Dept of Agriculture. Composition of Foods: Poultry Products, 1979. Agricultural handbook 8-5.



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| Bloomfield, MI 48304  |           | Robert M. Elkus, MD  | 00     | Jeanette J. Gluszewski, MD   | D1.4      |
| <b>Peter F. Czako, MD</b> 3535 W. 13 Mile #645                          | GS/END    | 6777 W. Maple Rd.<br>W. Bloomfield, MI 48322                             | GS     | 6767 W. Outer Drive<br>Detroit, MI 48075   | PM        |
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| <b>David Deutsch, MD</b><br>208 Fieldcrest                              | PD        | 600 Lafayette E. J624<br>Detroit, MI 48226                               | P/FP   | 5825 Ortonville #103<br>Clarkston, MI 48346  | DR        |
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| Michael L. Mawby, MD<br>1221 6th St., Ste. 206<br>Traverse City, MI 49684             | RHU/IM | Kurt Olson, MD<br>Sand Point Road<br>Munsing, MI 49802                            | FP  | Kristine O. Rudolf, MD<br>688 Brookwood<br>Rochester Hills, MI 48309       | FP            |
| Robert Compton May, MD<br>P.O. Box 995<br>Ann Arbor, MI 48106                         | IM/NEP | Lalit C. Parekh, MD<br>27600 Franklin Rd., Apt. "C"706<br>Southfield, MI 48034    | PD  | Raimes A. Rudolf, MD<br>1500 Walton Blvd.<br>Rochester Hills, MI 48309     | FP            |
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| Egenia A. McKim, MD<br>31500 Telegraph #100<br>Birmingham, MI 48025                   | PD     | Chester L. Pflugrad, MD<br>1255 N. Oakland Blvd., Ste. 100<br>Waterford, MI 48327 | FP  | Continue   | ed on page 63 |



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| Abul H.M. Shamsuddoha, MD<br>455 S. Livernois Rd., Ste C-23<br>Rochester Hills, MI 48307 | GE/IM  | <b>Diana C. Soulias, MD</b><br>23800 Orchard Lake Rd., Ste. 10<br>Farmington Hills, MI 48336 | 00 FP   | Bryan Weinstein, DO<br>4208 Sedgemoore Lane<br>Bloomfield Hills, MI 48302       | Р     |
| Brian Shapiro, MD<br>G-5119 W. Bristol Rd.<br>Flint, MI 48507                            | GS     | Paul D. Stein, MD<br>2799 W. Grand Blvd.<br>Detroit, MI 48202                                | IM/CD   | Jennifer Wetzel, MD<br>30695 Little Mack Ste. 200<br>Roseville, MI 48066        | FP    |
| Roger Silverstein, MD<br>31500 Telegraph #100<br>Birmingham, MI 48025                    | PD     | Guat Sy Jr., MD<br>1700 Hubbard Dr., #700<br>Dearborn, MI 48126                              | GS/R    | <b>Alicia Williams, DO</b><br>1535 Gull Rd., Ste. 105<br>Kalamazoo, MI 49001    | IM/CD |
| Patricia A. Smith, MD<br>22770 Clarkshire Drive<br>South Lyon, MI 48178                  | PD     | Scott G. Thomas, MD<br>St. Joseph Mercy Hospital<br>Ann Arbor, MI 48106                      | GS      | Bradford Woelke, MD<br>1255 N. Oakland Blvd., Ste. 100<br>Waterford, MI 48327   | FP    |
| Sidney J. Smith, MD<br>730 N. Macomb St., Ste 223<br>Monroe, MI 48161                    | OB/GYN | Paul J. Treusch, MD<br>1255 N. Oakland<br>Waterford, MI 48327                                | FP/E    | <b>Thurza Wright, MD</b><br>7733 E. Jefferson<br>Detroit, MI 48214              | PD    |
| Robert A. Snapp, MD<br>338 Village Green Blvd. #107<br>Ann Arbor, MI 48108               | AN     | April Tyler, DO<br>10785 S. Saginaw, Ste. B<br>Grand Blanc, MI 48439                         | FP      | <b>Gerald G. Yutzy, MD</b><br>22249 Wick Rd.<br>Taylor, MI 48180                | R     |
| Janet Burg Snider, MD<br>16100 Sherfield<br>Southfield, MI 48075                         | PD     | Nitin G. Vaishampayan, MD<br>36973 Dartmoor Dr.<br>Farmington Hills, MI 48331                | RO      | <b>Gary R. Ziegler, MD</b><br>419 S. Coral St.<br>Kalkaska, MI 49646            | FP    |



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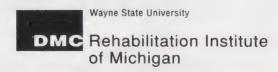
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## **MEETINGS**

### October

**12,** MSMS/MPMLC Practice Parameters: Cookbook Care...or the Recipe for Ensuring Quality?, Novi Hilton, Novi, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

13, 18, 19, 27, MSMS/MPMLC Risk Management: Closed Claim Reviews (Ophthalmology. October 13, WMU Regional Center, Grand Rapids, MI. October 18, Treasure Island, Saginaw, MI. October 19, MSMS Headquarters, East Lansing, MI. October 27, MPMLC Metro office, Bloomfield Hills, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

**14-15,** MSMS Medical Biller Training Series: Medicare. MSMS Headquarters, East Lansing, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

**15-16,** MSMS Health Effects of Great Lakes Pollution. Radisson on the Lake, Ypsilanti, MI. Contact: Mary Anne Ford,

Manager, Medical Economics and Health Care Delivery, (517) 336-5721.

**18, 19, 20, 21, 22,** MSMS Exceptional Medical Assistant. October 18, Grand Traverse Resort, Traverse City, MI. October 19, Fetzer Center, Kalamazoo, MI. October 20, Hotel Baronette, Novi, MI. October 21, Treasure Island, Saginaw MI. October 22, WMU Regional Center, Grand Rapids, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

**20, 21,** MSMS/MPMLC Fundamentals of Risk Management. October 20, Grand Traverse Resort, Traverse City, MI. October 21, Novi Hilton, Novi, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-13451.

**27,** MSMS Pain and Symptom Management for the Incurably III: Alternatives to Assisted Suicide, Westin Hotel, Detroit, MI. Contact: Tracy Baker, MSMS Communications, (517) 336-5786.

### **November**

**3, 4,** MSMS/MPMLC Risk Management; Colon and Prostate Cancer: Avoiding Two Common Malpractice Traps. November 3, WMU Regional Center, Grand Rapids, MI. November

**4,** Novi Hilton, Novi, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

**4, 5,** MSMS Medical Biller Training Series: Medicaid. Novi Hilton, Novi, MI. Contact: The Office of Physician Education, (517) 336-5784.

**9-11,** MSMS Annual Scientific Meeting, Westin Hotel, Detroit, MI. Contact: Sarah Cressman, MSMS Assistant for Physician Education, (517) 336-5727.

**16, 17,** MSMS/MPMLC Fundamentals of Risk Management. November 16, Fetzer Center, Kalamazoo, MI. November 17, Port Huron Hospital, Port Huron, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

Continued on following page

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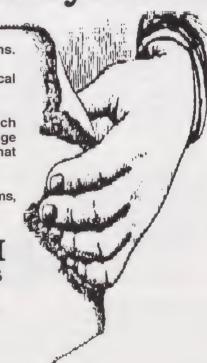
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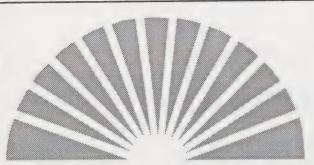
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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon\* is indicated as a sympathicolytic and mydriatric. It may have activity as an approxisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug. 1.2 Also dizziness, headache, skin flushing reported when used orally. 1.3

**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence. <sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References

- 1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
- Goodman, Gilman The Pharmacological basis of Therapeutics 6th ed., p. 176-188.
   McMillan December Rev. 1/85.
- 3. Weekly Urological Clinical letter, 27:2, July 4, 1983
- A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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## **MEETINGS**

Continued from page 61

**18-19,** MSMS Orientation to the Medical Office. Treasure Island, Saginaw, Ml. Contact: The Office of Physician Education, (517) 336-5784.

**24,** MSMS Pain and Symptom Management for the Incurably III: Alternatives to Assisted Suicide, Fetzer Center, Kalamazoo, MI. Contact: Tracy Baker, MSMS Communications, (517) 336-5786.

**30,** MSMS/BCBSM Medicare Update. Holiday Inn, Flint, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

## Michigan Specialty Society Meetings

### October

**22-23,** Michigan Sleep Disorders Association, Holiday Inn, Traverse City, MI. Contact: Edward Stepanski, (313) 972-1800.

## **AMA Meetings**

### October

**23,** Physicians' Forum: Agenda for Action, San Francisco, CA. Call 800-621-8335 for details and registration information.

### November

**5,** Physicians' Forum: Agenda for Action, Dallas, TX. Call 800-621-8335 for details and registration information.

**20,** Physicians' Forum: Agenda for Action, Philadelphia, PA. Call 800-621-8335 for details and registration information.

## December

**5-8,** AMA Interim Meeting, New Orleans, LA. Contact: Judy Marr, Manager, MSMS Department of Communications and Professional Relations, 517-336-5744.

National Specialty Society Meetings

### October

**13-17,** American Society of Internal Medicine Leadership Development Conference, Portland, OR. Contact: Melinda Klein, (202) 835-2746, ext. 266.

**21-22**, National Association of Managed Care Physicians, Managed Care in the 90's. Contact: Laura Russell, 800-722-0376.

**29-31,** American Society of Bariatric Physicians, Westin Hotel, Chicago, III. Contact: (303) 779-4833.

### November

**4-7,** American Pain Society 12th Annual Scientific Meeting, Buena Vista Palace, Lake Buena Vista, Orlando, FL. Contact: Cynthia Porter, (708) 966-5595.

## **Other Meetings**

### October

**28-31,** Society for Professional Well-Being Conference Helps Health Professionals Meet Change. Contact: Marjorie Harrison, (919) 489-9176.

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## CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

### October

5, 6, 7, Providing Outstanding Patient Service. Location: October 5, Treasure Island, Saginaw, Michigan. October 6, Novi Hilton, Novi, Michigan. October 7, MSMS Headquarters, East Lansing, Michigan. Sponsor: Michigan State Medical Society. Contact: Office of Physician Education, (517) 336-5784. Approved for: 6 hours Category I

7.8. American Russian International Sports medicine Symposium, Location: Michigan Athletic Club, East Lansing, Michigan. Sponsor: Michigan State Medical Society. Contact: Office of Physician Education, (517) 336-5784. Approved for: 12 hours Category I

9, Gastrointestinal Disorders for Primary Physicians. Location: Grand Valley State University. Sponsor: Blue Cross Blue Shield of Michigan. Contact: Ms. Grace Dyk, 600 Lafayette East, Detroit, MI 48226-2998, (616) 285-2054. Approved for: 4 hours Category I Credit.

12, MSMS Risk Management Seminar, "Medical Practice Parameters." Location: Novi Hilton, Novi Michigan. Sponsor: Michigan State Medical Society and Michigan Physicians Mutual Liability Company. Contact: Julie Smith, MSMS Chief, Risk Management. Approved for: 3.5 hours Category | Credit.

16, Newest Concepts in Ophthalmic Diagnosis and Therapy. Sponsor: Franklin Eye Consultants. Location: Northfield Hilton, Troy, Michigan. Contact: Hugh Beckman, MD 29275 Northwestern Hwy, Suite 100, Southfield, MI 48034, (313) 353-1750. Approved for: 5.5 hours Category I Credit.

17-18, Fiberoptics Workshops for the Difficult Airway. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Department of Anesthesiology. Contact: Melody Curry, Registrar, Office of Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157. Approved For: 17 hours Category I Credit.

22-23, Contraceptive Update/No-Scalpel Vasectomy. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Continued on following page



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## **CATEGORY I COURSES**

Continued from page 69

Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 15 hours Category I Credit.

**27,** Effective Compassion for the Incurably III: Alternatives to Assisted Suicide. Location: Westin Hotel, Detroit, Michigan. Sponsor: Michigan State Medical Society. Contact: Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48826-0950, (517) 336-5784. **Approved for:** 3.5 hours Category I Credit.

**28-29,** Colonoscopy/Common Anorectal Disorders/Hemorrhoids. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 11.5 hours Category I Credit.

**29,** Therapeutic Strategies for Thoracic Neoplasms Update 1993. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan

Medical School, Department of Radiation Oncology. **Contact:** Melody Curry, Registrar, Towsley Center for Continuing Medical Education, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 6.5 hours Category I Credit.

29, Second Annual Symposium the Mental Health Care of the Elderly: Affective Disorders in the Geriatric. Location: The Ritz Carlton, Dearborn. Michigan. Sponsor: The Tri-County CMH Consortium Detroit-Wayne. Macomb, and Oakland Community Mental Health Boards and Detroit Riverview Hospital and Macomb Hospital Center. Contact: Michele Reid. MD. Detroit-Wayne County Community Mental Health Board, 10th Floor, Book Building, 1249 Washington Blvd. at Grand River, Detroit, MI 48226, (313) 224-2830. Approved for: 5.25 hours Category I Credit.

**29-30,** Stress EKG. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Mid-

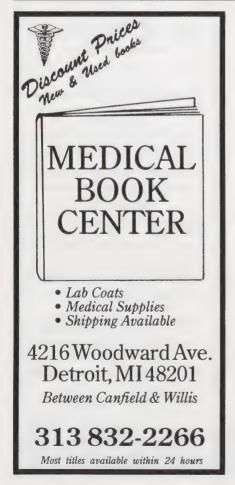
land, MI 48640, 1-800-462-2492. Approved for: 11.5 hours Category I Credit.

### November

**3, 4,** Diagnosis and Management of Colon & Prostate Cancer. Location: November 3, WMU Regional Center, Grand Rapids, Michigan. November 4, Novi Hilton, Novi, Michigan. **Sponsor:** Michigan State Medical Society and Michigan Physicians Mutual Liability Company. **Contact:** Julie Smith, MSMS Chief, Risk Management, (517) 337-1351. **Approved for:** 5 hours Category I Credit.

**4-5,** An Update in Neonatology: The Horizon....and Beyond. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Department of Pediatrics. Contact: Melody Curry, Registrar, Towsley Center for Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. Approved for: 13 hours Category I Credit.

Continued on page 72





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#### **CATEGORY I COURSES**

Continued from page 69

4-5, Selected Topics in Clinical Nutrition. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School and College of Pharmacy. Contact: Melody Curry, Registrar, Office of Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. Approved for: 11 hours Category I Credit.

5-6, Colposcopy for the Primary Care Physician. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallman, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 12 hours Category I Credit.

6, LEEP. Location: Ashman Court Hotel. Midland, Michigan, Sponsor: The National Procedures Institute. Contact: Linda Allmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 5.75 hours of Category I 7, Colposcopy Update. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 7.5 hours of Category I Credit.

**8,** The Team Approach to the Silence of Violence: Developing Hospital-**Based Family Violence Programs:** Wayne County Medical Society, Detroit, Michigan. Sponsor: Michigan State Medical Society. Contact: Office of Physician Education, (517) 336-5784. Approved for: 7 hours Category I Credit.

10-11, Potpourri #3. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 15 hours Category I Credit.

19-20. Sclerotherapy/Peripheral Vascular Evaluation. Location:

Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 11.5 hours of Category I

19-20, Advances in Psychiatry V 1993. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Department of Psychiatry. Contact: Melody Curry, Registrar, Towsley Center for Continuing Medical Education, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. Approved for: 14 hours Category I Credit.

23-28, Pediatric Board Review. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Michigan Association of Pediatric Program Directors, Michigan Chapter, American Academy of Pediatrics. Contact: Marie McKnight, Registrar, Towsley Center for Continuing Medical Education, University of

Continued on page 74

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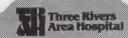
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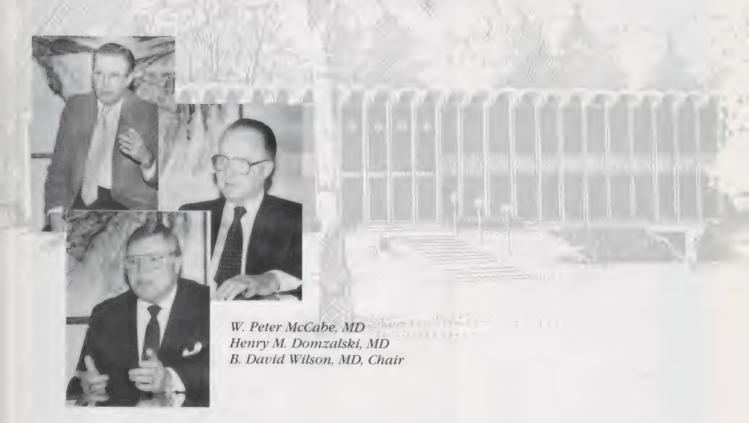
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### MICHIGAN STATE MEDICAL SOCIETY GROUP INSURANCE TRUST

### CATEGORY I

Continued from page 72

Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 936-9800. **Approved for:** 60 hours Category I Credit.

**24,** Effective Compassion for the Incurably III: Alternatives to Assisted Suicide. Location: Fetzer Center, Kalamazoo, Michigan. Sponsor: Michigan State Medical Society. Contact: Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48826-0950, (517) 336-5784. **Approved for:** 3.5 hours Category I Credit.

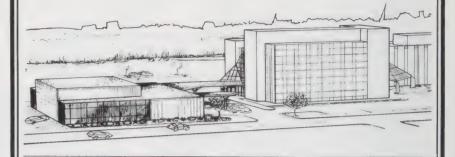
#### December

**3-4,** 2nd Annual Women's Health Care for the Primary Care Provider. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Department of Family Practice and Department of Obstetrics and Gynecology. Contact: Melody Curry, Registrar, Towsley Center for Continuing Medical Education, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. Approved for: 14 hours Category I Credit.

#### **January**

**24-26,** Fiberoptics Workshops for the Difficult Airway. Location: Disney's Yacht Club Resort, Lake Buena Vista, Florida. **Sponsor:** University of Michigan Medical School, Department of Anesthesiology. **Contact:** Melody Curry, Registrar, Towsley Center for Continuing Medical Education, P.O. Box 1157, Ann Arbor, MI 48106-1157. **Approved for:** 16 hours Category I Credit.

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#### **Oakwood Health Services**

Oakwood Health Services, located in southeast Michigan, is recruiting qualified BC/BE physicians to affiliate with its hospital network, which includes:

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Oakwood Hospital, Oakwood Health Services' largest facility, offers extensive educational and training programs, including accredited residency programs in Obstetrics and Gynecology, Family Practice, Internal Medicine, Radiology, and a Transitional Program.

#### Ob/Gyn Faculty

Excellent opportunity for a clinically oriented general Ob/Gyn to join the faculty of the 16 position, Ob/Gyn Residency program at Oakwood. The program is supported by three subspecialties.

Faculty positions available are:

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#### **Family Practice Opportunities**

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#### **Orthopedic Private Practice**

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For information on these and other opportunities with Oakwood Health Services, please contact: Oakwood Physician Support Services, P.O. Box 2719, Dearborn, MI 48123-2719; 1-800-222-0154, Fax: 1-313-292-2628.

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PEDIATRICIAN, BC/BE: To join busy, well-

established general pediatrics practice in a desirable far northern suburb of Chicago. This future partnership opportunity offers competitive compensation and benefits, family-oriented lifestyle, excellent schools and park district, and easy access to Chicago. For information, please contact Susan Kilpatrick, Director of Physician Outreach, Condell Medical Center, 900 Garfield Ave., Libertyville, IL 60048; (708) 362-2905, ext 5280. You may also simply fax your CV and cover letter to (708) 362-1721.

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Continued from page 78

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| Metpath of MI               |         |
|                             |         |

| Metro Renab                 | 08  |
|-----------------------------|-----|
| Mood Institute              | 69  |
| MPMLC                       |     |
| MSMS Group Insurance Trust  | 73  |
| Mt. Clemens Hospital        | 58  |
| National Livestock          | 56  |
| National Medical            |     |
| Nationwide Collections      | 39  |
| North Memorial              | 78  |
| PAC-Comp                    | . 8 |
| Paine Webber                |     |
| Palisades Pharm             | 66  |
| PC Medical                  | 78  |
| Physician Service Group     | . 1 |
| PICOMII                     | FC  |
| Premier                     |     |
| Professional Practice Sales | 79  |
| Rehab Institute             | 64  |
| Riverview Clinic            |     |
| Rollins Health Care Systems | 44  |
| Rossman Martin              | 14  |
| Select Care                 | 60  |
| Sisters of St. Joe          | 67  |
| SSi Medical                 |     |
| St. Luke's 37,              |     |
| Stratton Cheeseman & Walsh  | 59  |
| Sunshine Leasing            |     |
| Thompson Recruitment        |     |
| Three Rivers                |     |
| Trans Global Tours          | 71  |
| Transnational               | . 6 |
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## PRESIDENT'S PAGE

#### Health System Reform-Another False Start?

By Gilbert B. Bluhm, MD

he delayed release of President Clinton's health system reform plan reaffirms the complexity of this social issue.

What seems to be the prime factor that drives health system reform? According to Vermont Governor Dean (a physician), it is the insecurity of the American middle class who fear the loss of current health benefits provided by employers. It is not, as he recently said, a concern to provide

health care to the uninsured. A recent statement by leaders of the United Auto Workers (UAW) that the loss of any current health benefits was unacceptable in UAW negotiations seems to substantiate Gov. Dean's thesis.

To most of us physicians, and other health care providers, it is the escalating costs of health care which are driving us toward health system reform. Unless we are naive or a sleepy "Rip Van Winkle," we realize most other reasons are a charade.

The medical profession hasn't been confronted with a major social change in health reform since Medicare and Medicaid. The government must not legislate short term cost reduction gain that produces long term patient and physician pain! Government and business alike champion the idea that health care is in crisis because it costs too much and they denigrate the best medicine in the world, overstate and sometimes misstate why a large group of the uninsured choose to gamble with their health, and mislead with statistics the true number of citizens without insurance coverage. Some of those same "champions" for change deny the wasted cost of our medical liability "tort" system, the role of defensive medicine, ineffective administrative oversight, irrational duplicative paper trails about patient services, and ignore a public need for preventative health measures and healthy lifestyles. Add to that a citizenry that expects daily lifesaving miracles from the advances in medical technology, and there's big trouble for reform!



As the Clinton health system reform plan is hammered out, certain elements are sure to prevail. There will be universal health coverage with a basic or standard benefit package. Some type of National Health Board will be created to concoct a basic health benefit package and budget limitations for the USA. How this will be apportioned to the various States will be politically determined, rather than by documented data or need. Employers will

be required to provide health benefits for their employees. Attempts to control costs will limit the choice of physicians as well as other health provider organizations. Physicians will form more partnerships among themselves to survive and with some hospitals in "accountable health plans" where all must assume financial risk. Some limited form of price controls will exist in geographic regions with sparse populations who have limited numbers of physicians available to them. Our current medical education system will be altered financially and specialty training will be controlled. The pharmaceutical industry will get a regulatory "hit." Medical "high" technology will be limited in its application. New developmental research and quality medical care will be a struggle to maintain. Some type of reform legislation will be enacted before another congressional election. A transitional period for change will be allowed at least until the 1996 election.

If you care about physician autonomy and wish to choose your practice sites, partners, fees, hospitals, consultants, specialization, and medical education, but fear rationed health services, misuse of practice parameters, taxation of health providers, underfunded federal and state health programs and loss of control to manage your patient's care, NOW is the time to prepare yourself to enter the fray to achieve proper health system reform for our patients and the profession. Let us work together to improve the scenario described!

"The gem cannot be polished without friction nor man perfected without trials." (Confucius)

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Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).
Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolenia. Cholesterol and other products of cholesterol biosynthesis are essential components for Itetal development (including synthesis of steroids and cell membranes). Since HMG-COA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal arm when administered to pregnant women. Therefore, HMG-COA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

MARNINGS

Elver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare nations.

rare patients. As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinua-

tion of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravas tion or inerapy may warrant consideration of liver loopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism), Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

patients should be closely monitored, started at the lower end of the recommended dosing range, and turated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle acting or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper little of prograduation in conformation to provide their conformation. of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (or 1/%), Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. Pravastatin therapy should be discontinued if markedly elevated CPK (sevels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major sur-

the development of renal failure secondary to rhabdomyolysia, e.g., sepais; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozii, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin
together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients
who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with
pravastatin and gemfibrozii showed a trend toward more frequent CFK elevations and patient withdrawals due to
unusculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving
placebo, gemfibrozii, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS:
Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated
regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment
continued. The use of fibrates alone may occasionally be associated with myopathy. The combined use
of pravastatin and fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.

avastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS).

This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin. Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3a-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean ALC values and half-life (t/2) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Glown this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tendemess or weakness, particularly if accompanied by malaise or fever.

weakness, particularly if accompanied by malaise or fever.

Drug interactions: Immunosuppressive Drugs, Gernfibrozil, Niacin (Nicotinic Acid), Erythromycin: See WARN-INGS. Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system with occur.

chrome P450 system will occur.

Cholestyramine/Colestypoir-Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before codestipol and a standard meal, there was no clinically significant decrease in blow-availability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfann: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bloavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not after the plasma protein-binding of warfann. Concomitant dosing did increase the AUC and Cmax of warfarin before the plasma protein-binding of warfann. Concomitant dosing did increase the AUC and Cmax of warfarin before the plasma protein-binding of warfann. Concomitant dosing did increase the AUC and Cmax of warfarin before the plasma protein-binding of warfann. Concomitant dosing did increase the AUC and Cmax of warfarin before the plasma protein-binding of warfann. Concomitant dosing did increase in the anticomorphism time after alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Crax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed. Cimetidine: The AUC<sub>0+12hr</sub> for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid. Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability parameters of digoxin were not affected. The AUC of pravastatin related to increase, but the overall bioavailability as a significant decrease in urnary excretion and profetio binding of pravastatin. In addition, there was a significant increase in AUC, Crmax, and Timax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemiflorozii is generally not recommended.

In interaction studies with aspirin, antacids [1 hour prior to PRAWACHOL (pravastatin sodium)], cimetidine, incotinic acid, or probucol, no statistically significant differences in bioavailability were seen when PRAWACHOL was administered.

was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-block

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circu Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesteral synthesis and lower circulated cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced (p<0.004) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects and HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitany-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that the levels or activity of steroid hormones.

etidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell

infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class. A chemically similar drug in this class produced optic nerve degeneration (Mallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulicochiear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 80 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose. Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 1, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose (p<0.01). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

highest dose (p<0.01). Although rate were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls (p<0.05). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mich and high-dose females. They treatment also significantly increased the incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Prug treatment also significantly increased the incidence of algonomas of the liver was significantly increased in high-dose males. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose males and females. Adenomas

also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls. No evidence of mutagenicity was observed in vitro, with or without rail-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of Salmonella typhimurium or Escherichia coli; a forward mutation assay using Saccharomycas cerevisiae. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice. In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis; including epididymal maturation). In rats treated with this same entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same entire cycle of Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear. of these findings is unclea

of these findings is unclear 
Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS. 
Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 
1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20k (rabbit) or 240k (rat) 
the human exposure based on surface area (mg/meter). However, in studies with another HIMS-Cort eductase 
inhibitor, skeletal malformations were observed in rats and mice. PRAWACHOL (pravastatin sodium) should be 
administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have 
been informed of the potential hazards. If the woman becomes pregnant while taking PRAWACHOL, it should be 
discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAWACHOL should not nurse (see 
CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: General.) **ADVERSE REACTIONS** 

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic sent transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trails the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% orwanatatin-treated patients in the placebo-controlled trials are identified in the table below, also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

|                     | All Events %             |                      | Events Attributed to Study Drug % |                      |
|---------------------|--------------------------|----------------------|-----------------------------------|----------------------|
| Body System/Event   | Pravastatin<br>(N = 900) | Placebo<br>(N = 411) | Pravastatin<br>(N = 900)          | Placebo<br>(N = 411) |
| Cardiovascular      |                          |                      |                                   |                      |
| Cardiac Chest Pain  | 4.0                      | 3.4                  | 0.1                               | 0.0                  |
| Dermatologic        |                          |                      |                                   |                      |
| Rash                | 4.0°                     | 1.1                  | 1.3                               | 0.9                  |
| Gastrointestinal    |                          |                      |                                   | 0.0                  |
| Nausea/Vomiting     | 7.3                      | 7.1                  | 2.9                               | 3.4                  |
| Diarrhea            | 6.2                      | 5.6                  | 2.0                               | 1.9                  |
| Abdominal Pain      | 5.4                      | 6.9                  | 2.0                               | 3.9                  |
| Constipation        | 4.0                      | 7.1                  | 2.4                               | 5.1                  |
| Flatulence          | 3.3                      | 3.6                  | 2.7                               | 3.4                  |
| Heartburn           | 2.9                      | 1.9                  | 2.0                               | 0.7                  |
| General             | 210                      | 1.0                  | 2.0                               | 0.7                  |
| Fatique             | 3.8                      | 3.4                  | 1.9                               | 1.0                  |
| Chest Pain          | 3.7                      | 1.9                  | 0.3                               | 0.2                  |
| Influenza           | 2.4*                     | 0.7                  | 0.0                               | 0.0                  |
| Musculoskeletal     | E-1-7                    | 0.7                  | 0.0                               | 0.0                  |
| Localized Pain      | 10.0                     | 9.0                  | 1.4                               | 1.5                  |
| Myalgia             | 2.7                      | 1.0                  | 0.6                               | 0.0                  |
| Nervous System      | 6-17                     | 1.0                  | 0.0                               | 0.0                  |
| Headache            | 6.2                      | 3.9                  | 1.7*                              | 0.2                  |
| Dizziness           | 3.3                      | 3.2                  | 1.0                               | 0.5                  |
| Renal/Genitourinary | 0.0                      | 0.2                  | 1.0                               | 0.0                  |
| Urinary Abnormality | 2.4                      | 2.9                  | 0.7                               | 1.2                  |
| Respiratory         | 6.7                      | 2.0                  | U.I                               | 1.2                  |
| Common Cold         | 7.0                      | 6.3                  | 0.0                               | 0.0                  |
| Rhinitis            | 4.0                      | 4.1                  | 0.0                               | 0.0                  |
| Cough               | 2.6                      | 1.7                  | 0.1                               | 0.0                  |

Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

The following effects have been reported with drugs in this class: Skeletal: myopathy, rhabdomyolysis. Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy. Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgh returnatios, vasculitis, purpura, thrombocytopenia, lemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chilis, flushing, malaise, dyspnea, toxic epidermal necrobisis, erythema multiforme. including Stevens-Johnson syndrome. ammins, ammaigia, urticaria, asthenia, photosensitivity, fever, chilis, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pencreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fullminant hepatic necrosis, and hepatoma; anorexia, vomiting. Reporductive: gynecomastia, loss of libido, erectitie dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite contin-Transient, asymptomatic eosinophilia has been reported. Eosinophil courts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and loukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestpol, nicotinic acid, probucol and gernifibroral. Preliminary data suggest that the addition of either probucol or gernifibroral that the reproduction or pravastatin is not associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdornydysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gernifibroral, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: Skeletal Muscle and PRECAUTIONS: Drug Interactions.)

OVERDOSAGE

ere have been no reports of overdoses with pravastatin. Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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# pravastatin sodium 20 mg tablets

PRAVACHOL is indicated as an adjunct to diet for the reduction of elevated total and LDL-cholesterol levels in patients with primary hypercholesterolemia (Types IIa and IIb) when the response to diet alone has not been adequate.

Active liver disease or unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of pravastatin sodium.

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.



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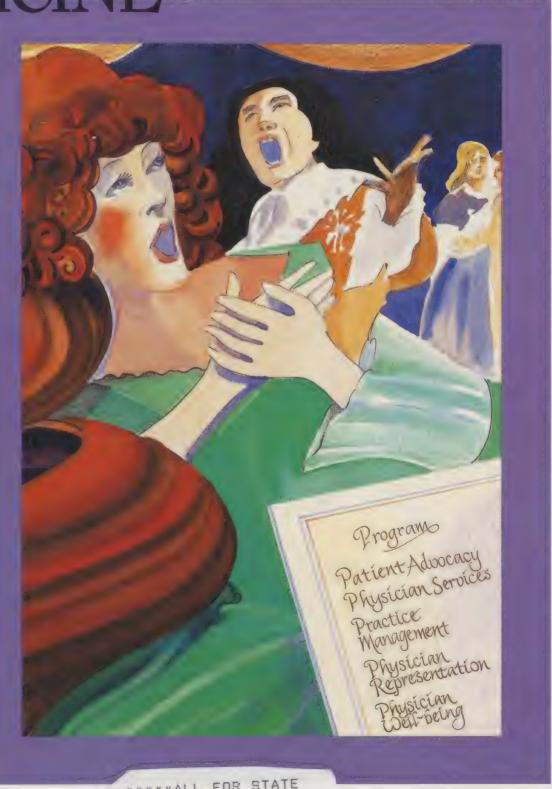
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#### Annual Report on MSMS Membership MSMS provides a strong voice for medicine

Take a moment to review the program

### Also included in this issue:

- MSMS-POMS division earns high marks
- PO/PHO survey results
- MSMS publishes domestic violence handbook
- Presidential profile
- Impaired physicians update
- Ownership of medical records



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### MICHIGAN MEDICINE

NOVEMBER 1993 VOLUME 92, NO. 11

Award-Winning Journal of the Michigan State Medical Society

#### **COVER STORY**

Now, more than ever, physicians need to remain united and to speak with one voice. A voice powerful enough to be heard – organized medicine. MSMS provides a strong voice for Michigan physicians on a variety of fronts. This month's cover story explores the many ways MSMS is working to keep its membership growing and strong. Included are: an introduction by Doctor Zako; an explanation of the Society's *Target Tomorrow* recruitment campaign; a rundown of the many services MSMS and its subsidiaries provide for MSMS members; a review of the Physicians Communications Network, the Physicians Legislative Network, and the Michigan Doctors' Political Action Committee (MDPAC); a report from the MSMS Alliance; and finally, a list of "Whom to Call at MSMS."



#### OTHER KEY ARTICLES

#### 11

#### **POs Hit the Ground Running**

After many months of discussion, debate and research, the move toward Physician Organizations (POs) in Michigan has burst forth in a sudden flowering of action.

By Ralph D. Ward

#### 14 MSMS PO/PHO Survey Results

Respondents to a recent MSMS survey on physician organizations and physician-hospital organizations cite enhanced autonomy, better patient care as the motivating factors for joining POs/PHOs.

#### 32

#### **MSMS AIDS Provider Education Project**

A look at some members of the Speakers Bureau.

### **34**Doctors and Others Join to Stem Domestic Violence

A 40-member coalition organized by MSMS recently announced a new program aimed at reducing domestic violence.

#### 38

**MSMS Presidential Profile:** Gilbert B. Bluhm, MD A single word sums up this leading physician: devotion.

By David K. Fox

#### 41 Impaired Physicians: New Law Stresses "Treatment Rather than Punishment"

By Ralph D. Ward

#### 45

#### **Access to Medical Records**

Learn the facts about patient rights.

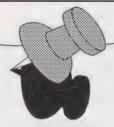
#### **DEPARTMENTS**

- 7 LETTERS
- 9 MSMS ON THE MOVE
- 16 LEGAL BRIEFS
- 37 REIMBURSEMENT ROUNDUP
- **50 NEW MEMBERS**
- 52 MEETINGS
- 55 CATEGORY I COURSES
- 59 CLASSIFIEDS
- **63 ADVERTISING INDEX**
- **64 PRESIDENT'S PAGE**

#### In next month's issue:

A review of health system reform

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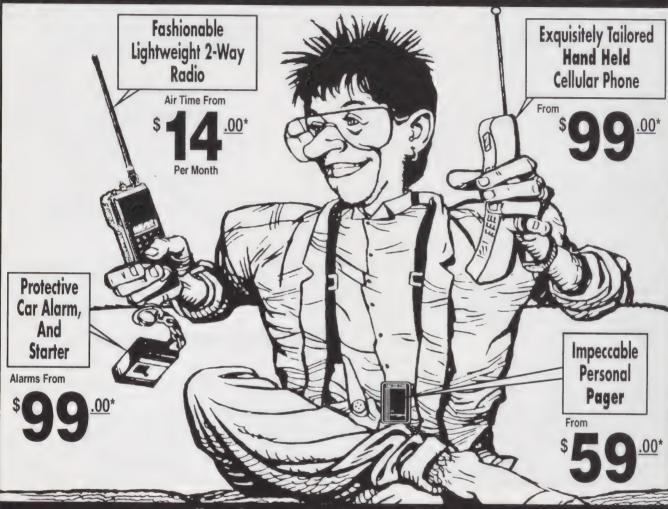
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### **LETTERS**

#### **MSMS** Conference praised

I wanted to thank you for inviting (me) to your superb conference on Physician Organizations and Physician-Hospital Organizations (September 10-11). Your panel of experts was very insightful and helpful, particularly when dealing with the nuts and bolts issues of common legal questions and the psychology of collaboration and trust. I found the entire conference to be on the cutting edge of physician/hospital relationships.

The Michigan State Medical Society should be proud of its efforts on behalf of its member physicians. Not only have you taken extraordinary steps to educate your physicians concerning their opportunities with physician/hospital organizations, you also have set up the management and organizational services subsidiary to help with the development process. I view this as a critical member service. Physicians would much rather deal with an organization they trust than entrepreneurial consultants. I (was) extremely impressed by your progressive ability to advocate on behalf of your member physicians. The comparisons to New York state are striking.

Thank you for letting (me) be a part of this innovative and educational seminar. Without a doubt, this will result in much discussion at a local level.

Thomas Bielefeldt, Executive Director Medical Societies of the Counties of Broome, Chemung, Delaware and Otsego, New York

#### MSMS newsletter lauded

Having had an interest in health care policy issues for the last several years, and having taken a six-month sabbatical to study such issues at Health Policy International, Princeton, New Jersey, I was delighted to receive the MSMS MD Data Newsletter, Data and Information for Physician Leaders.

There is no doubt that we need up-

to-date information concerning the rapidly changing environment that physicians are now facing in the delivery of health care for citizens in the State of Michigan and in the United States.

Rudi Ansbacher, MD, MS University of Michigan Medical Center

#### Lithuanian Wedical Association needs your help

We are the first medical association supporting development of private medical service in Lithuania. It was established in 1991. The association joined together about 300 members and we expect to grow.

We would like to ask you for assistance making contacts with American colleagues.

This year the Association was authorized by Health Ministry of Lithuania to set up the Methodical and Reorganizational Center for private medicine in Vilnius.

Thank you for your attention. We hope to hear from you soon.

Romualdas Gruzauskas, President Lithuanian Medical Association Traku 9/1-106, Vilnius 2001, Lithuania

#### Physician happy with State, MSMS

I moved from Michigan to Pennsylvania after I finished my pediatric residency at Hurley Medical Center in Flint, to join Pittsburgh Childrens Hospital for a fellowship in pediatric neurology.

I really enjoyed my stay in Michigan as well as your Society membership.

Thank you very much for your attention and the services you (provide to) Michigan physicians. I thank Genesee County Medical Society for the same.

Doctor Afaneh Monroeville, PA

#### Influenza surveillance for the 1993-94 season

Each year in Michigan, hundreds of people die as a result of the complica-

tions of influenza. Public health authorities need the help and cooperation of Michigan physicians in their efforts to promptly determine the type, geographic distribution and amount of influenza that is occurring.

The Centers for Disease Control and Prevention anticipates that influenza A may predominate this season. As you are aware, in past years, illness due to influenza A has been more severe than that due to Type B.

Michigan local health departments will be coordinating epidemiologic surveillance of influenza for their areas of jurisdiction. Prompt reporting of increases in influenza-like illness to local health authorities is important because prophylaxis and treatment decisions depend on it.

A limited number of specimen collection kits are available for use in outbreak situations through local health departments. Testing of specimens for individual diagnostic purposes will not be available through the MDPH laboratory again this influenza season.

Your assistance in reporting increases in influenza-like illness to local health authorities is very much appreciated.

Mary Grace Stobierski, DVM, MPH Communicable Disease Epidemiologist, Disease Surveillance Section, Michigan Department of Public Health



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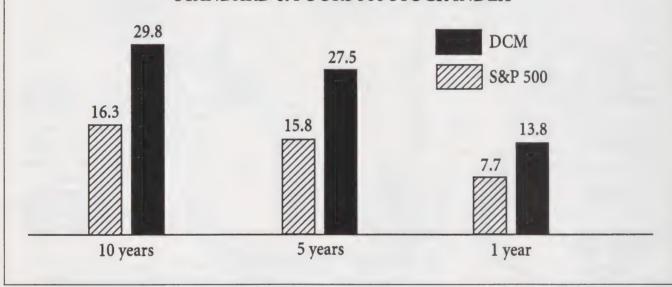
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# VISINS ON THE MOVE

#### A monthly update of key MSMS activities



#### MSMS programs connect doctors with lawmakers

Health system reform is at the top of both state and national legislative agendas. Because some of the biggest changes ever in organized medicine are taking place right now, it's important that physicians talk regularly with lawmakers on how those changes should happen.

MSMS has two programs to help doctors do that. One is the "1994 Capitol Checkup." This day-long annual event, sponsored by MSMS and the MSMS Alliance, is set for April 20. It will bring physicians and legislators together to talk about health system reform and other issues. Call the MSMS Department of Government Relations at (517) 336-5741 for details.

The other program is the MSMS "Doctor of the Day." Physicians come to Lansing and spend an entire day with their legislators. The program provides them with a chance to observe and take part in the legislative process. Call Greg Aronin at (517) 336-5739 to set up a visit.

#### **Target Tomorrow!** seeks to strengthen organized medicine

Physician unity in a time of change is important if organized medicine is to continue moving forward. That unity includes encouraging physicians who currently are not MSMS members to join organized medicine.

Target Tomorrow! "Membership that Matters" is a peer-to-peer physician outreach campaign to increase MSMS membership. Started at the Sept. 22 MSMS Board of Directors meeting, the campaign will continue through June 1994 with a target of 200 new members. MSMS is asking physicians to talk with their peers and share with them information about the advantages of MSMS membership.

MSMS will present awards to the top recruiters, as well as each physician who participates. The top prize will be a camel blazer for the physician who recruits the most new members for MSMS. Other awards include watches with the MSMS seal for recruiters who recruit more than 10 new members and a leather portfolio with the MSMS seal for physicians who recruit between five and ten new members.

If you have questions about the program, or would like recruiting assistance, such as a list of nonmembers in your area, call Deborah Zannoth at (517) 336-5763.

#### Mark your calendars for these important MSMS meetings in 1994!

#### March 9-10

MSMS Maternal and Perinatal Health Conference at the Ritz-Carlton in Dearborn. Call Sarah Cressman at (517) 336-5727 for meeting details.

#### March 11-12

MSMS Joint Section Meeting at the Ritz-Carlton in Dearborn. Call Tom Plasman at (517) 336-5724 for details on the Hospital Medical Staff Section, Betty McNerney at (517) 336-5749 for information about the Section for International Medical Graduates, and Deborah Zannoth at (517) 336-5763 for information on the Young Physicians Section.

#### May 6-8

MSMS House of Delegates at the Amway Grand Plaza in Grand Rapids. AMA House of Delegates Speaker Daniel H. Johnson, MD, will address the MSMS House on May 6. MSMS accepts resolutions until 30 days prior to the meeting. Call Donna Farougi at (517) 336-5735 for information.

For details on these and other issues call William E. Madigan, Executive Director, at MSMS 517/337-1351.

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# POs Hit the Ground Running

By Ralph D. Ward



fter many months of discussion, debate and research the move toward physician organizations (POs) in Michigan has burst forth in a sudden flowering action. A number of POs are now either in operation or are in the final stages of preparation throughout the state—and just in time, too.

With President Clinton's September unveiling of national health reform plans, the prospect of a massive redefinition of health care players looms. Although HMOs, group practice, and similar trends have been moving physicians away from the world of individual practice for years, the single physician will face unheard-of new challenges with reform. The "health care alliances" called for in the initial Clinton plan would "market health care insurance... in bulk" in the words of a recent U.S. News and World Report article. Economic logic tells us that when a purchaser buys a product in massive, generic quantities—the way the alliance will buy health care-sellers had better come to the table with their own quantity advantages. When dealing with coverage plans that encompass whole states, and millions of people, practitioners who are not themselves part of a powerful team risk becoming medically marginal.

Hence, physician organizations suddenly look very attractive indeed. "POs allow physicians to be proactive instead of reactive to change," says MSMS Chief of Physician Organization Development Bill Carbone. When combined with changes in the relationship between physicians and hospitals, the trend toward POs becomes irresistible.

#### A fast-moving trend

Indeed, not only is the trend irresistible, it's fast moving. The Oakland Physicians Network held its first organizational meeting on September 28. The group will be composed of physicians on the medical staff of Pontiac St. Joseph Mercy Hospital. The PO had its genesis when the staff at St. Joseph in Pontiac "elected a committee to look into the potential of establishing a PO," according to Bashar Succar, MD, who chaired the committee. Doctor Succar. an otolaryngologist, believes POs can help physicians thrive in these challenging times. "They can help us meet the need for good quality medicine, for reasonable costs, and for a strong primary care base. A PO will make us better able to compete with other interests, and better able to respond to health care reforms." In their dealing with hospitals, notes Doctor Succar, when physicians "enter into discussions individually, the hospital mostly runs affairs. When a PO enters into a relationship with a PHO, things function much better for the physicians."

Like other new POs, the Oakland group took advantage of the MSMS-Physician Organization & Management Services (POMS) division. MSMS Board member Frederick V. Minkow, MD, who attended the September 28 organizational meeting of the Oakland Physicians Network, is impressed. "This is not a pie in the sky concept," he said. "The Oakland Physicians Network was organized by respected leaders of the hospital medical staff with the invaluable assistance of the consultants brought together by the MSMS-POMS. It has great potential."

Doctor Succar expressed similar praise for the MSMS-POMS. "I think the MSMS-POMS was quite instrumental in getting us in the right direction," he said. "They helped us by recommending a consultant and recommending an attorney. They were really a great help."

According to Dean Smith, PhD, an assistant professor of health services, management and policy at the University of Michigan and an MSMS consultant, it is particularly important to develop a strategic plan before forming a PO. MSMS asked Smith to help the Oakland group as a strategic planner during the development phase. After an extended five-month planning phase for the PO, the pace of formalizing the group has suddenly quickened. "There

Continued on following page

Continued from page 11

has been a big and sudden spurt in development [of POs]," says Smith. "The reasons were made abundantly clear when President Clinton unveiled his health reform package." Smith sees this new interest as part of a longerterm physician trend toward managed care. "There is a need for physicians to be organized in larger numbers to respond to managed care contracts. Contractors prefer to work with large numbers of physicians, particularly when unified contractors can prove they're cost effective." Smith predicts that physician networks are inevitable. It's only a matter of whether market forces or government action will bring them about. "You can do it yourself, or someone will do it for you."

#### Flexibility a key feature of POs

The flexibility of the PO concept is one of its greatest strengths, says Smith. "POs are hard to define. Some are started for no more than collective purchasing, and at the other extreme are HMOs. Most are somewhere in the middle, though, allowing physicians to become involved in managed care, negotiate effectively with hospitals, start management services, and generally increase productivity."

Despite this flexibility, POs must be careful to avoid liability threats built into our current legal system. "There are antitrust concerns if the PO is not designed correctly," says Smith. "The PO might be considered a bargaining unit, or be found to collectively boycott a contractor, or set prices."

"I think the MSMS-POMS (Physician Organization and Management Services) was quite instrumental in getting us in the right direction. They helped us by recommending a consultant and recommending an attorney. They were really a great help."



Succar

Still, "we have a pretty reasonable regulatory infrastructure," according to Smith, who predicts that the Clinton changes will not sacrifice antitrust activism for any easing of competitive restraints facing doctors. "I doubt there will be much in the Clinton changes to encourage POs." Smith says that the MSMS-POMS offers services needed to set up the best legal and organizational structure for budding POs.

In the future, the formation of POs will likely continue to mushroom, but there are a number of built-in limitations. Smith observes that "POs will likely continue to be built around geographic boundaries. Defining patient populations and essential needs are best handled at the local level." He also sees little likelihood of statewide POs. "Physicians in Detroit and Marquette are not in the same market."

As an indicator of how fast-moving the PO trend is, one of the most-established groups in the state is only three years old. The Livingston Physicians Group formed in 1990 and presently has 41 members, most of whom are affiliated with McPherson Hospital in Howell. Group President Ismael D. Yanga, MD, who also is chief of staff at McPherson, recalls that the group began with "a consensus among doctors that we needed a physician-driven organization, and that we not just rely on hospitals." This, he believes, reflects the view that "the most cost effective way of having a voice heard is through the PO.

Indeed, Doctor Yanga's group reflects the growing wisdom that a healthy PO is an effective first step in building a good Physician-Hospital Organization. "We are organizing a PHO at the moment." Doctor Yanga sees the PO unifying the voices of physicians involved in the PHO, but that this voice also is there to be a positive working partner, not an adversary. "The hospital is not the enemy," says Doctor Yanga. Formation of this PHO will occur with the assistance of the MSMS-POMS. "We just didn't have the expertise."

In essence, then, Doctor Yanga sees POs as "a vital first step needed for physicians to be listened to." This need for physicians "to be listened to" is a theme that arises again and again in discussions on POs. "Physicians know how to run the organization and make it cost effective. However, that sort of expertise was not recognized. Physicians need to show that we are not the 'problem' with health care."

The Livingston Group's history offers valuable lessons for dealing with the organizational problems that are inevitable with POs. "What's most needed [in a PO] is collegiality and trust, and learning to see how we can



Minkow

"This is not a pie in the sky concept. The Oakland Physicians Network was organized by respected leaders of the hospital medical staff with the invaluable assistance of the consultants brought together by the MSMS-POMS. It has great potential."

improve the system. We also need to have a strong, dedicated board of directors, willing to sacrifice time, their personal life and income."

Such pressure, sure to increase as POs take their place in national health care policy, can lead to danger points for the PO. "The greatest danger is infighting," says Doctor Yanga. "There is a risk of losing trust in the executive committee. Thankfully, this has not been a problem so far." Still, just because physicians recognize the need for POs, they do not necessarily take well to being voked in a common harness. "It's not easy to have one unified idea. If you have 15 physicians. you have 15 ideas." Dissent between the changing demands for and rewards of specialty practice and primary care also have proven to be fertile ground for policy disputes.

#### Larger networks possible

Larger *networks* of individual POs may be in the cards. Among the Michigan groups now in operation or in the works is the Michigan Provider Network (MPN). According to MPN President Gerald Sherman, MD, the MPN, set to begin operating in January, will comprise physicians from 10 metro Detroit area hospitals: William Beau-

mont - Troy, William Beaumont - Royal Oak, Botsford Hospital, Crittenton Hospital, Sinai Hospital, Macomb Hospital Center, St. John Hospital, St. Joseph Mercy - Pontiac, and St. Mary Hospital in Livonia. Doctor Sherman, an otolaryngologist affiliated with William Beaumont - Troy, says that MPN will actually serve as a network of POs involved with these individual hospitals. "We hope to have the process completed by January," says Doctor Sherman, who adds that current membership is about 750 physicians, but that the network hopes to eventually reach 2000.

Indeed, Doctor Sherman observes that the current MPN network of 10 hospitals is only "phase one" of growth. "There may be other POs as needed. Phase two is to bring in more POs."

Why go the PO route? According to Doctor Sherman, without such unity, physicians cannot "participate in reform. There is a change in relationships underway, and, with the health care alliances forming, we'll need large physician networks to do the contracting." Sherman predicts similar large-scale provider networks will be forming in other states as well.

Ralph Ward is a Lansing-based freelance writer.

#### MSMS/MPMLC Announces "The Masters Series: Cornerstones to Successful Health System Reform"

MSMS/MPMLC stands ready to assist physicians with the formation of physician organizations (POs) and physician hospital organizations (PHOs).

Already, MSMS/MPMLC has held one seminar and one two-day in-depth conference on POs/PHOs. A second two-day conference is slated for February 25-26, 1994, at the Ritz Carlton Hotel, Dearborn.

These conferences on various aspects of health system reform have been slated for 1994 as part of *The Master Series*:

- Managed Care, January 13, 1994, Embassy Suites, Southfield
- PO/PHO Conference: The Sequel, February 25-26, 1994, Ritz Carlton Hotel, Dearborn
- Negotiations/Anti-trust, March 11, 1994, Ritz Carlton Hotel, Dearborn
- Physician Data Requirements, April 21, 1994, Embassy Suites, Southfield Further details and registration information will appear in upcoming issues of *Medigram*.



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### MSMS conducts PO/PHO survey

Respondents cite enhanced autonomy, better patient care as the motivating factors for joining POs/PHOs

he majority of respondents (57 percent) to a recent MSMS PO/PHO survey cited enhanced autonomy and improved patient care as the motivating factors for joining a PO or PHO. Forty-three percent cited changes being proposed under health system reform as a motivating factor, while nearly a third said they are considering joining a PO or PHO to be able to bid for managed care patients (See Figure 1).

MSMS is interested in POs and PHOs because of the changes in the marketplace, particularly the trend toward managed care that gives physicians the choice of becoming employees or an equal partner in a health system.

To find out the extent to which physicians are aware of POs and PHOs, MSMS developed and distributed a PO/PHO survey to selected groups in early August. A total of 149 responses were received.

#### Figure 1

What factors are causing you to consider joining such an entity? (Percent indicating each factor as most important)

- 57% To organize more effectively to enhance autonomy and improve patient care
- 43% Changes being proposed under health system reform
- 32% To be able to bid for managed care patients
- 23% Local business/industry is putting out health care request for proposal
- 21% Corporations are taking bids from organized groups of physicians only
- 11% The ability to leave business matters to the entity and return to the practice of medicine
- 10% The hospital is employing physicians

Figure 2

Awareness of Initiatives in Your Community? MSMS PO/PHO Survey 1993

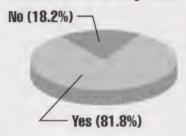


Figure 3

Structures Being Considered MSMS PO/PHO Survey 1993

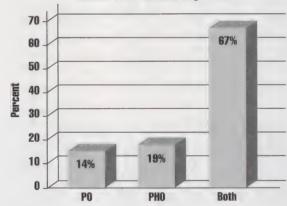


Figure 4

Consider Participating in a Structure MSMS PO/PHO Survey 1993



#### Additional results

The vast majority of respondents (82 percent) indicated they were aware of initiatives in their community to establish a PO or PHO (See Figure 2). In two-thirds of the cases, both a PO and PHO were being considered (See Figure 3). Nearly all of those aware of such activities are considering participating in the structure that is being proposed (See Figure 4).

#### Early stages of development

Most respondents consider the organizational development of POs or PHOS to be in the early stages. Thirty-three percent indicated they are in the information gathering/educational stage; thirty percent said they are in preliminary discussions on organizational structure; and twenty-four percent said structure is proposed and physicians are making the decision to join. Only a small proportion say that a structure is actually in place (See Figure 5).

#### Figure 5

In what stage of development is this entity?

- 33% Information gathering/educational
- 30% Preliminary discussions on organizational structure
- 24% Structure is proposed and physicians are making the decision to join
- 7% Structure is in place and physicians have been selected
- 7% Structure is seeking to bid on health care contracts

#### Assistance needed

Nearly a third of physicians responding said they need some type of assistance in evaluating or organizing the entities that are being proposed. Organizational analysis, legal and tax services, and strategic and business planning are the services needed most often (See Figure 6).

#### Figure 6

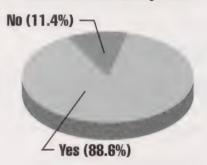
What type of assistance do you need in evaluating or organizing these entities? (Please circle all that apply)

- 39% Organizational analysis
- 36% Legal/tax services
- 31% Personnel management, compensation, education
- 28% Quality assessment/quality assurance
- 30% Risk management
- 26% Data analysis and utilization review
- 26% Computer information systems
- 29% Practice management, marketing and communications
- 27% Financial/accounting services
- 36% Strategic and business planning

Of the 18 percent of respondents who were not aware of PO or PHO activity in their area, 89 percent felt that investigating these alternatives is a worthwhile activity in light of market changes (See Figure 7).

#### Figure 7

#### No Activity, But Worth Investigating MSMS PO/PHO Survey 1993



### The following definition was used for the purpose of the MSMS PO/PHO survey:

A physician organization (PO) is a group of physicians, single or multiple specialties, who form a business entity to prepare for changes resulting from health care reform. It is composed only of physicians, but is not necessarily a medical staff. The two broad models are a group practice or an organization that represents a network of physicians seeking managed care contracts. The PO may form a physician hospital organization (PHO) with a hospital or hospital system to pursue one or more cooperative ventures designed to improve some aspect of health care delivery in the community. A PO or PHO can provide physicians with the opportunity to maintain control over the clinical aspects of medicine, while taking advantage of their hospital's administrative and marketing expertise and access to capital.



Editor's Note: If you have a legal question you would like answered by MSMS legal counsel in this column, jot it down and send it to Betty McNerney, Editor of Publications, at MSMS.

### Enterprise Liability A Dangerous Quick Fix

By Monte D. Jahnke

educing physician exposure to malpractice by creating a system based on enterprise liability has appeal. The Clinton Administration's health care proposal includes enterprise liability as one of its features, although by means of demonstration projects only. The proposal will advocate supplying federal funds to the states to establish demonstration projects. The projects would seek to determine whether substituting health plan liability for physician liability leads to improvements in the quality of health care, and reduces defensive medicine in conformance with improved risk management techniques. Just how this proposal will evolve once the Clinton plan is debated in Congress is anyone's guess. For now, risk managers, physicians, and others interested in professional liability need to keep this idea under very close scrutiny.

Risk managers might justifiably conclude that the handling of incidents and lawsuits might be streamlined under an enterprise liability setting. The idea that only the enterprise (be it a hospital or an accountable health plan) should stand liable for patient injury may eliminate infighting among defendants, conflicting interests (and the separate counsel that go with them), and the coordination of various insurance and self-insurance arrangements necessary to configure settlements or to satisfy judgements. One defendant with one pot of money, a single counsel, and a singular set of interests certainly has its appeal. Unfortunately, this concept may suffer from all of the problems associated with trying to configure a simple answer to a very complex problem.

One fundamental flaw is that the enterprise liability concept as articulated to date proposes no reciprocal changes in underlying fundamental tort law. Beyond making the enterprise the solely responsible party, there is no proposal to invoke damage caps, modify rules of discovery,

recognize collateral sources, or tighten statutes of limitations in order to modify overall loss exposure. Hospitals or accountable health plans with ultimate liability will become institutional deep pockets without proven and reasonable limitations on exposure. The policy development dialogue in Washington has thus proposed a bonanza for the plaintiffs' bar without tort law trade-offs. Such one-sided policy "wonking" does nothing to solve the national liability crisis.

#### A question of constitutional law

This primary design flaw exists alongside several implementation issues of no less import. Tort law as applied to the medical malpractice area is largely if not exclusively a creature of state, not federal, law, Just how the federal government could invoke the enterprise liability concept by usurping the tort law of each of the several states presents a fairly large question of constitutional law. Supposedly. incentives or program design requirements which assume that the legislatures of the states will bring their tort laws into compliance with the federal standard will be used in implementing the federal reforms. Many legislatures nationally have already grappled unsuccessfully with tort reform, largely for constitutional and political reasons of their own. Even assuming that federal health reform could solve some of the state political issues, serious constitutional questions remain at the state level about insulating practitioners and laying all potential liability exposure at the enterprise level.

The fact that some states have achieved tort reform yields a national patchwork of tort rules. State reforms vary widely and enterprise liability may provide no uniformity. A reformed federal model dependent on enterprise liability may become dysfunctional or at least only marginally effective. Like today's system, outcomes will still depend on the law of a particular state, at least for the foreseeable future... Little or no relief from the overall liability exposure of the entire system will occur nationally.

Just how an enterprise liability case would be proven and defended presents another significant consideration. At a recent Washington, DC, question-and-answer session on the Clinton reform proposal no one was able to describe just how such a case would be handled, who would be allowed to testify for or against whom, and what safeguards might exist for requiring proof of a breach of any standard of institutional or professional care. My basic assessment of the program as described at that session was that enterprise liability is a no-fault system shrouded in health reform rhetoric.

Continued on page 17

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A hybrid *blending of tolerability and power* that's available for the right patient. Vaseretic is indicated for the treatment of hypertension in patients for whom combination therapy is appropriate.

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USE IN PREGNANCY: When used in pregnancy during the second and third trimesters. ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, Vaseretic<sup>8</sup> (Enalapril Maleate-Hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

ASERETIC® 10-25 Enalapril Maleate-Hydrochlorothiazide

Next

Dosage must be individualized; the fixed combination is not for initial therapy.

Evaluation of the hypertensive patient should always include assessment of renal function.

For a Brief Summary of Prescribing Information, see adjacent pages.

USE IN PREGNANCY: When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC (Enalapril Maleate-Hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

CONTRAINDICATIONS: VASERETIC is contraindicated in patients who are hypersensitive to any component of this product and in patients with a history of angioedema related to previous treatment with an angiotensin converting enzyme inhibitor. Because of the hydrochlorothiazide component, this product is contraindicated in patients with anuria or hypersensitiv ity to other sulfonamide-derived drugs.

WARNINGS: General; Enalapril Maleate; Hypotension: Excessive hypotension

WARNINGS: General: Enalapril Maleate: Hypotension: Excessive hypotension was rarely seen in uncomplicated hypertensive patients but is a possible consequence of enalapril use in severely salt/volume depleted persons such as those treated vigorously with diuretics or patients on dialysis. Syncope has been reported in 1.3 percent of patients receiving VASERETIC. In patients receiving enalapril alone, the incidence of syncope is 0.5 percent. The overall incidence of syncope may be reduced by proper tritration of the individual components. (See PRECAUTIONS, Drug Interactions, and ADVERSE REACTIONS.)

In patients with severe congestive heart failure, with or without associated renal insufficiency, excessive hypotension has been observed and may be renal insufficiency, excessive hypotension has been observed and may be associated with oliguria and/or progressive azotemia, and rarely with acute renal failure and/or death. Because of the potential fall in blood pressure in these patients, therapy should be started under very close medical supervision. Such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart or cerebrovascular disease, in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses, which usually can be given without difficulty once the blood pressure has increased after volume expansion.

after volume expansion.

after volume expansion.

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis and/or larynx has been reported in patients treated with angiotensin converting enzyme inhibitors, including enalapril. In such cases VASERETIC should ing enzyme inhibitors, including enalapril. In such cases VASERF-IR, should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. Where there is involvement of the tongue, glottis or larger lifety cause involvement of proporties the proposition of the strong of the str larynx, likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL) and/or measures necessary to ensure a patent airway, should be promptly provided. (See ADVERSE

REACTIONS.)
Patients with a history of angioedema unrelated to ACE inhibitor therapy may be at increased risk of angioedema while receiving an ACE inhibitor (see also CONTRAINDICATIONS).

(see also CONTRAINDICATIONS).

Neutropenial/Agaunulocytosis: Another angiotensin converting enzyme inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patents but more frequently in patients with renal impairment especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered. lar disease and renal disease should be considered

that disease and disease should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal

tunction.

Thazides should be used with caution in patients with impaired renal function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma.

The possibility of exacerhation or activities.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Lithium generally should not be given with thiazides (see PRECAUTIONS, Drug Interactions, Enalaprii Malonte and Hydrochlorothiazide). Pregnancy: Enalaprii-Hydrochlorothiazide retratogenicity in rats given up to 90 mg/kg/day of enalapril (150 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 ½ times the maximum human dose) or in mice given up to 30 mg/kg/day of enalapril (50 times the maximum human dose) or in mice given up to 30 mg/kg/day of enalapril (50 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2) ½ times the maximum human dose) mg/kg/day of hydrochlorothiazide (2 1/2 times the maximum human dose) ng/kg/day of right the translation of the translati

mg/kg/day of enalapril-hydrochlorothiazide in rats and 10/10 mg/kg/day of enalapril-hydrochlorothiazide in mice when used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASFRETIC should be discontinued as soon as possible. (See Enalaprii Maleate, Fetal/Neonatal Morbidity and Mortality, Delow). Enalaprii Maleate, Fetal/Neonatal Morbidity and Mortality. ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literatus. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

as possible.

The use of ACE inhibitors during the second and third trimesters of preg-nancy has been associated with fetal and neonatal injury, including hypoten sion, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure.

whether these occurrences were due to the ACE-inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of pregnant, physicians should make every effort to discontinue the use of VASERETC as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no \*Registered trademark of Hospal Ltd

10 25 mg mg

alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultra sound examinations should be performed to assess the intraamniotic envi

If oligohydramnios is observed VASERETIC should be discontinued

If oligohydramnios is observed, VASERETIC should be discontinued unless it is considered lifesaving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as means of reversing hypotension and/or substituting for disordered renal function. Enalapril, which crosses the placenta, has been removed from neonatal circulation by peritoneal dialysis with some clinical benefit, and theoretically may be removed by exchange transfusion, although there is no experience with ed by exchange transfusion, although there is no experience with

be removed by exchange transfusion, although there is no experience with the latter procedure.

No teratogenic effects of enalapril were seen in studies of pregnant rats, and rabbits. On a mg/kg basis, the doses used were up to 333 times (in rats), and 50 times (in rabbits) the maximum recommended human dose. Hydrochlorothiazide, Teratogenic Effects: Reproduction studies in the rabbit, the mouse and the rat at doses up to 100 mg/kg/day (50 times the human dose) showed no evidence of external abnormalities of the fetus due to hydrochlorothiazide. Hydrochlorothiazide given in a two-litter study in rats at Goses of 4.5 fem/kg/day (approximately 1.2 times the usual daily burnan nvorteriorounazioe: rydrictimonazioe giveri na avvolinter sutusi in tassi doces of 4 - 5 c mg/kg/day (approximately 1 - 2 times the usual daily human dose) did not impair lertility or produce birth abnormalities in the offspring. Thiazides cross the placental barrier and appear in cord blood.

Nontretalogenic Effects: These may include fetal or neonatal jaundice, throm-bocytopenia, and possibly other adverse reactions which have occurred in

PRECAUTIONS: General; Enalapril Maleate; Impaired Renal Function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe congestive heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with angiotensin converting enzyme inhibitors, including enalapril, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and for death

tailure and/or death. In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20 percent of patients. These increases were almost always reversible upon discontinuation of enalapril and/or disuretic therapy. In such patients renal function should be monitored during the first few weeks of

Some patients with hypertension or heart failure with no apparent p existing renal vascular disease have developed increases in blood urea a serum creatinine, usually minor and transient, especially when enalapril has been given concomitantly with a diuretic. This is more likely to occur in patients with pre-existing renal impairment. Dosage reduction of enalapril and/or discontinuation of the diuretic may be required.

Evaluation of the hypertensive patient should always include assess-

ment or renal runction. Hemodaliyis Patients: Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes  $(eg, AN 6^9)$  and treated concomitantly with an ACE inhibitor. In these patients consideration should be given to using a different type of dialysis membrane or a different class of

given to using a different type of dialysis membrane or a different class of antihypertensive agent. 
Hipperkalemia: Elevated serum potassium (greater than 5.7 mEq/L) was observed in approximately one percent of hypertensive patients in clinical trials treated with enalapril alone. In most cases these were isolated values which resolved deseptic continued therapy, all othough hyperkalemia was acuse of discontinuation of therapy in 0.28 percent of hypertensive patients. Hyperkalemia was less frequent (approximately 0.1 percent) in patients treated with enalapril plus hydrochlorothizatice. Rusk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements and/or comitant use of potassium-sparing diuretics, potassium supplements and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with enalapril. (See Drug Interactions.)

all, with enalapril. (see Drug Interactions.)

Cough: Cough has been reported with the use of ACE inhibitors.

Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/Anesthesia: In patients undergoing major surgery or during an thesia with agents that produce hypotension, enalapril may blo angiotensin II formation secondary to compensatory renin release hypotension occurs and is considered to be due to this mechanism, it can be

hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Warning signs or symptoms of fluid and electrolyte imbalance, irrespective of cause, include dryness of mouth, thirst, weakness, lethargy,

spective of cause, include dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, contision, seizures, muscle pairs or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or after prolonged therapy. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia may cause cardiae arrhythmia and may also sentine or expensed to the propose. cause cardioc arrivhtmia and may also sensitize or exagerate the response of the heart to the loxic effects of digitalis (e.g., increased ventricular irribability). Because enalapril reduces the production of aldosterone, concentral therapy, with enalapril attenuates the diuretic-induced potassium loss (see

merapy with enalopin attenuates the culturen-cinduced potassium loss (see Drug literactions, Agents Increasing Serum Potassium).

Although any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease), chloride replacement may be required in the

treatment of metabolic alkalosis

Treatment or inetationic arkatosis.

Dilutional hyponatremia may occur in edematous patients in hot weather, appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life-threatening. In actual

except in rare instances when the hyponatremia is ine-increating, in actual sail depletion, appropriate replacement is the therapy of choice. Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

In diabetic patients dosage adjustments of insulin or oral hypoglycemic agents may be required. Hyperglycemia may occur with thiazide durretics. Thus latent diabetes mellihus may become manifest during thiazide therapy. The antihypertensive effects of the drug may be enhanced in the postsym-

pathectomy patient.

If progressive renal impairment becomes evident consider withholding or

pathectomy patient.

If progressive renal impairment becomes evident consider withholding or discontinuing diuretic therapy.
Thiazides have been shown to increase the urinary excretion of magnesium; this may result in hypomagnesemia.

Thiazides may decrease urinary calcium excretion. Thiazides may cause intermittent and slight letevation of serum calcium in the absence of known disorders of calcium metabolism. Marked hypercalcemia may be evidence of hidden hyperparathyroidism. Thiazides should be discontinued before carrying out tests for parathyroid function.

Increases in cholesterol and triglyceride levels may be associated with thiazide diuretic therapy.

Information for Patientis, Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All natients chould he eautioned that excessive perspiration and dehydra-

the third is the days of iterapy. It actual synope occurs, the tients should be told to discontinue the drug until they have consulted the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to con-

may also lead to a fall in blood pressure; patients should be advised to consult with the physician. Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician. Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia. Pregnancy: Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible. NOTE: As with many other drugs, certain advice to patients being treated with VASERETIC is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible

safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions; Enalapril Maleate; Hypotension—Patients on Diuretic Therapy. Drug Interactions: Enalapril Maleate: Hypotension—Patients on Diuretic Therapy. Patients on diuretic sand especially those in whom diuretic therapy was recently instituted, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS.)

Agents Causing Renu Reloss: The antihypertensive effect of enalapril is autemented by antihypertensive agents that cause preint please (e.g., diuretic autemented by antihypertensive agents that cause preint please (e.g., diuretic diuretic agents).

augmented by antihypertensive agents that cause renin release (e.g., diuret-

Other Cardiovascular Agents: Enalapril has been used concomitantly with beta adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine and prazosin without evidence of clinically significant adverse interactions.

adverse interactions.

Agents Increasing Serum Potassium: Enalapril attenuates diuretic-induced potassium loss. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia they should be used with caution and with frequent monitoring of serum potassium.

monitoring of serum potassium.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant enalapril and lithium and were reversible upon dis-continuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium. Hydrochlorothiuzide, When administered concurrently the following drugs

may interact with thiazide diuretics:

Alcohol, barbiturates, or narcotics—potentiation of orthostatic hypotension may occur. Antidiabetic drugs (oral agents and insulin)—dosage adjustment of the

Antidiabetic drugs (oral agents and insulin)—dosage adjustment of the antidiabetic drug may be required.

Other antidiperiensive drugs—additive effect or potentiation.

Cholestyramine and colestipol resins—Absorption of hydrochlorothiazide is impaired in the presence of anionic exchange resins. Single doses of either cholestyramine or colestipol resins bind the hydrochlorothiazide and reduce its absorption from the gastrointestinal tract by up to 85 and 43 percent, respectively.

Corticosteroids, ACTH—intensified electrolyte depletion, particularly

hypokalemia.

hypokalemia. Pressor amines (e.g., norepinephrine)—possible decreased response to pres-sor amines but not sufficient to preclude their use. Skeletal muscle relavants, nondepolarizing (e.g., tubocurarine)—possible increased responsiveness to the muscle relavant. Lithium—should not generally be given with diuretics. Diuretic agents reduce the renal clearance of lithium and add a high risk of lithium toxicity. Refer to the package insert for lithium preparations before use of such preparations with VASERETIC. Musclemidel Articinelmusters Druge. In some patients the administration.

preparations with VASEKETIC.

Non-steroidal Anti-inflammatory Drugs—In some patients, the administration of a non-steroidal anti-inflammatory agent can reduce the diuretic, natriuretic, and antihypertensive effects of loop, potassium-sparing and thiazide diuretic. Therefore, when VASEKETIC and non-steroidal anti-inflammatory agents are used concomitantly, the patient should be observed closely to determine if the desired effect of the discretic is obtained.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Enalapril in combination

with hydrochlorothiazide was not mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril-hydrochlorothiazide did not produce DNA single strand breaks in an *in vitro* alkaline elution assay in rat hepatocytes or chromosomal aberrations in an in vivo mou

Enterind Model: There was no evidence of a tumorigenic effect when enalapril was administered for 106 weeks to rats at doses up to 90 mg/ $k_B/dav$  (150 times' the maximum daily human dose). Enalapril has also been administered for 94 weeks to raile and female mice at doses up to 90 and 180 mg/ $k_B/dav$ , respectively, (150 and 300 times' the maximum daily dose for humans) and showed no evidence of care

with or without metabolic activation. Enalpari lwas also negative in the Ames microbial mutagen test with or without metabolic activation. Enalpari lwas also negative in the following genotoxicity studies: rec-assay, reverse mutation assay with £; of, sister chromatid exchange with cultured mammalian cells, and the micronucleus test with mice, as well as in an in vivo cytogenic study using mouse bone marrow.

There were no adverse effects on reproductive performance in male and female rats treated with 10

There were no adverse effects on reproductive performance in male and female rats treated with 10 to 90 mg/kg/day of enalapin!

If you of enalapin!

Whythrokinorithuzide: Two-year feeding studies in mice and rats conducted under the auspices of the National Toxicology Program (NTP) uncovered no evidence of a carcinogenic potential of hydrochlorothiazide in female mice (at doses of up to approximately 600 mg/kg/day) or in male defender ats (at doses of up to approximately 100 mg/kg/day). The NTP, however, found equivocal evidence for hepatocarcinogenicity in male mice.

Hydrochlorothiazide was not genotoxic in vitro in the Ames mutagenicity assav of Salmonella typhimumum strains TA 98, TA 100, TA 1535, TA 1537, and TA 1538 and in the Chinese Hamster Ovary (CHO) test for chromosome al aberrations, or in vitro in assays using mouse germinal cell chromosomes, Chinese hamster bone marrow chromosomes, and the Drisophila sex-linked recessive lethal trait gene. Positive test results were obtained only in the in vitro CHO Sister Chromatid Exchange (clastogenicity) and in the Mouse Lymphoma Cell (mutagenicity) assays, using concentrations of hydrochlorothiazide from 43 to 1300 µg/mL, and in the Aspergillus nidulans non-disjunction assay at an unspecified concentration.

Hydrochlorothiazide had no adverse effects on the fertility of mice and rats of either sex in studies wherein these species were exposed, via their diet, to doses of up to 100 and 4 mg/kg, respectively, prior to conception and throughout gestation. 
Preynancy, Preynancy Calegorias C (first trimester) and D (second and third trimesters). See WARNINGS, Preynancy, Enalagrif Malaits, Fetal/Neonatal Morbidity and Morbidity. Nursing Mothers: Enalagrid and enalagridat are detected in human milk in trace amounts. Thiazides do appear in human milk. Because of the potential for serious reactions in nursing infants from either drug, a decision should be made whether to discontinue nursing or to discontinue VASERETIC, taking into account the importance of the drug to the mother.

a decision should be made whether to discontinue nursing or to discontinue VASERETIC, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: VASERETIC has been evaluated for safety in more than 1500 patients, including over 300 patients treated for one vear or more. In clinical trials with VASERETIC no adverse experiences peculiar to this combination drug have been observed. Adverse experiences that have occurred, have been limited to those that have been previously reported with enalapril or the safety of the control of the properties of the safety of the safe hydrochlorothiazide

occurred, have been limited to those that have been previously reported with enalapril or hydrochlorothiazide.

The most frequent clinical adverse experiences in controlled trials were: dizziness (8.6 percent), headache (5.5 percent), fatigue (3.9 percent) and cough (3.5 percent), dates experiences occurring in preater than two percent of patients treated with VASERETIC in controlled clinical trials were: muscle cramps (2.7 percent), natusea (2.5 percent), asthenia (2.4 percent), orthostatic effects (2.3 percent), impotence (2.2 percent), and preater than transparences occurring in 0.5 to 2.0 percent of patients in controlled trials included: Body As A Whole: Syncope, chest pain, abdominal pain; Cardioviscular: Orthostatic hypotension, palpitation, tachycardia; Digestire: Vomitting, dyspepsia, constipation, flatulence, dry mouth, Nervous/Psychiatric: Insomnia, nervousness, paresthesia, somnolence, vertigo; Sim: Pruritus, rash; Oller: Dyspnea, gout, back pain, arthralga, diaphoresis, oceraesed libido, tinnitus, urinary tract infection.

Angioedema: Angioedema has been reported in patients receiving VASERETIC (0.6 percent), Angioedema associated with larvngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis and/or larvnx occurs, treatment with VASERETIC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS).

\*\*Hypotension:\* In clinical trials, adverse effects relating to hypotension occurred as follows: hypotension (0.9 percent), orthostatic hypotension (1.5 percent), other orthostatic effects (2.3 percent). In addition syncope occurred in 1.3 percent of patients. (See WARNINGS).

\*\*Coulin: Below Urra Nitrogen:\* In controlled clinical trials minor increases in blood urea nitrogen and service of the patients with several indicated with VASERETIC. More marked increases have been reported in other enalapril experience. Increases are more likely to occur in patients with renal artery stenosis. (See PRECAUTIONS.

\*\*Serum Uric & Cili. Glicose, Magnesium,

preported in other enalapril experience. Increases are more likely to occur in patients with renal artery stenosis (See PREAUTIONS).

Serum Unr. Acid. Clincose, Magnesium, and Calcium: See PRECAUTIONS.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g percent and 1.0 vol percent, respectively) occur frequently in hypertensive patients treated with VASERETIC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, Jess than 0.1 percent of patients discontinued therapy due to anemia.

Liver Function Tests: Rarely, elevations of liver enzymes and/or serum bilirubin have occurred.

Other adverse reactions that have been reported with the individual components are listed below and, within each category, are in order of decreasing severity.

Enalapril Mulatic—Enalapril has been evaluated for safety in more than 10,000 patients. In clinical trials adverse reactions which occurred with enalapril were also seen with VASERETIC. However, since enalapril has been marketed, the following adverse reactions have been reported: Body As A Whole: Anaphylactoid reactions (see PRECAUTIONS, Homedaliysis Patients): Cardiovascular: Cardica arest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high risk patients (see WARNINGS, Hypotension); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances including atrial tachveardia and bradycardia, airial fibrillation; hypotension; angina pectoris; Digestive: Ileus, pancreatitis, hepatic failure, hepatitis (hepatocellular [proven or rechallenge] or cholestatic paudicle), melena, anorexal, glossifis, stomathis, dry mouth; Henatologic: Rare cases of neutropenia, thrombov (begin and bone marrow depression, confusion, ataxia, peripheral neuropathy (e.g., paresthesia, dysesthesia); Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS), flank pain, gynecomasta; Respindory: Pulmonary inflirates, bronchospasm, pne

Fetal/Neomatal Morbality and Mostality: See WARNINGS, Prognancy, Enalapril Maleate, Fetal/Neomatal Morbality and Morbality and Morbality and Morbality and Morbality and Morbality Hydrix International Morbality Hydrix International Morbality Hydrix International Hydroxide States and Applicational Hydroxide States and International Hydroxide States Intelligence and International Hydroxide States Intelligence and International Hydroxide States Intelligence Intelligence and International Hydroxide States Intelligence Intell

\* Based on patient weight of 50 kg

For more detailed information, consult your DuPont Pharma Representative or see Prescribing Information.



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#### **LEGAL BRIEFS**

Physicians and hospitals have guestioned what the enterprise liability concept might do to professional autonomy. Some question the potential for significant negative effects on patient care and the promotion of written practice mandates and standard setting by large institutions and accountable health plans because they will have ultimate liability. This could yield what some professional interests might characterize as the worse aspects of cookbook clinical practice devoid of judgement and replete with rule making and rule following. Perhaps this overstates the concerns but it certainly reflects the level of intense concern likely to be evident if the enterprise liability idea receives further attention.

Finally, we all need to keep in mind that enterprise liability in one form or another has, from time to time, been promoted by the plaintiff's bar in response to tort reform proposals. You too would like enterprise liability as a plaintiff's lawyer. It simplifies the initiation, management, and probably the trial and recovery of medical liability cases.

Just as all that glitters is not gold, enterprise liability could be disappointing and problematic. At least, that is, as currently being floated among the proposals for health care reform. Stay tuned.

Monte Jahnke is an attorney with Kerr, Russell & Weber, Detroit.

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### MSMS Provides a Strong Voice for Medicine

### Take a moment to review the program

By Louis R. Zako, MD



ow, more than ever, physicians need to remain united and to speak with one voice. A voice powerful enough to be heard -- organized medicine. MSMS provides a strong voice for Michigan physicians on a variety of fronts. However, maintaining a strong voice is dependent upon retaining and recruiting members.

As the new chair of the MSMS Committee on Membership Recruitment and Retention, I will strive to continually strengthen our ongoing recruitment and retention efforts. No matter how sophisticated our organization becomes, its life-blood must be an active, involved and growing membership.

Our *Target Tomorrow* recruitment campaign will allow MSMS to retain its strong membership base and excel in the vigorous representation of all physicians for which our organization is so well known. Information about our *Target Tomorrow* campaign is included in this cover story. Please study it closely and decide now to become active in our current recruitment efforts. MSMS strength is only as great as those who join and participate.

Play-or-pay. Global budgets. Managed competition. With every newspaper article, television interview and C-Span report, there is no question that the health system reform debate is underway. You owe it to yourself, your patients and the medical profession to stay involved.

Organized medicine supports health system reform. However, there are serious reservations about the current proposals because of the limit of physician choices, the increased degree of regulation and the lack of clearly defined financing mechanisms

In the coming months, the AMA and MSMS will be aggressively representing you at Congressional and state legislative hearings. Your organizations will propose constructive alternatives and strive to work with many other health care associations to transform the current health care system.

MSMS cannot go forward with this effort on behalf of physicians and patients unless it continues to have a strong, vital and expanding membership. A robust and growing membership allows MSMS to function effectively in the areas that are so important to all of us.

MSMS already is on the leading edge of change with the establishment of its Physician Organization and Management Services (POMS). POMS has positioned physicians in Michigan to adapt to the rapidly changing health care delivery environment. MSMS continues to provide the latest information and services which assist our members to adjust to the most current changes in the health care system.

I owe a great debt of gratitude to Dorothy Kahkonen, MD, immediate past-chair of the MSMS Committee on Membership Recruitment and Retention and current vice speaker of the MSMS House of Delegates, who kept our membership strong and healthy. I also am grateful to MSMS President Gilbert B. Bluhm, MD, who continues to make membership one of his top priorities during his tenure.

With your help and involvement with our recruitment efforts, MSMS will remain an essential player in the health system reform debate in Michigan. We must continue to strive to provide the best health care possible -- for our patients, our families and ourselves.





November 1993

TO: All MSMS Members

FROM: Gilbert B. Bluhm, MD

President

Louis R. Zako, MD Chair,

Committee on Membership Recruitment & Retention

RE: TARGET TOMORROW!

SMS is the largest trade association in the state serving members of the medical profession and we would like to retain that distinction! There is no better person than you, a fellow physician, to recruit a new member for organized medicine. You know the problems the medical profession is faced with and you know what organized medicine is trying to do to solve those problems.

TARGET TOMORROW is a peer-to-peer physician outreach campaign. The goal of the campaign is to increase overall membership in each category through the direct recruitment efforts of current members. MSMS has had a very successful year, succeeding in obtaining professional liability legislation, and creating a new service POMS (Physician Organization & Management Services) to assist physicians manage the tremendous changes in the health care delivery system. Competitive pressures and changing market conditions are particularly evident and have permanently altered the traditional fee-for-service share of our medical markets.

MSMS has now become an effective resource for information regarding these developments. A lot of nonmembers are not aware of what organized medicine does on behalf of *all physicians* in the state, and we, meaning all current members, need to spread the word. The theme of **TARGET TOMORROW** is organized medicine "membership that matters."

MSMS will present awards to the top recruiters, as well as each physician who participates. The top prize will be a camel blazer for the physician who recruits the most new members for MSMS (new members do not include residents or medical students.) Other awards include watches with the

MSMS seal for recruiters who recruit more than 10 new members and a leather portfolio with MSMS seal engraved on the cover for physicians who recruit between 5-10 new members. The county medical society with the highest percentage increase will also be honored for its recruiting efforts. Physician recruiters will have to indicate who they will be recruiting in order to receive credit for successfully enrolling new members by completing the card included with your recruitment material.

TARGET TOMORROW was unveiled at the Wayne County Medical Society Delegate Body meeting in August, distributed at the September Board meeting and presented at all MSMS committee meetings this fall. All recruiters are given physician outreach materials which include information from each level of organized medicine. The materials describe what each organization has accomplished recently, an application and a brochure about current membership benefits.

As physicians, we cannot be expert in all areas to adequately represent our interests and those of patients. However, our county, state and national medical societies are the most influential players in America's health care arena, and *the only organizations* that can effectively represent the profession on the important issues now confronting physicians!

If you would like recruiting materials, recruiting assistance, a list of nonmembers in your area, or help with a personalized letter campaign, please contact Deborah Zannoth, Chief of Membership Development, at MSMS headquarters, (517)336-5763.

Your MSMS
membership dollars
buy a piece of an
organization that works
hard to protect your
interests in the volatile
world of medicine and
health system reform.

edicine is under attack. This

much is obvious to anyone read-

ing the papers or watching the

news lately. With "missiles" being

launched from all sides physicians need.

more than ever, to remain united and to

speak with one voice— a voice powerful

enough to be heard-Organized Medi-

dues buy, peruse this list of recent

MSMS issues, projects and activities.

You'll see that working hard on your

If you wonder what your Society



attorney health care form.

#### **Domestic Violence**

The MSMS Task Force on Family Violence will continue to meet during the year, working to act on recommendations of a statewide coalition. The groups are studying what can be done in the areas of hospital-based programs, legal ramifications, legislative solutions, physician education and public awareness to help prevent family violence. MSMS staff liaison Judy Marr can answer your questions about the forum. Call her at (517) 336-5744.

#### AIDS Education

MSMS continues its work to educate physicians, other health care professionals and the public through its AIDS Provider Education Project Speakers Bureau. In 1992, 240 speakers reached more than 23,000 people. The Bureau filled requests for 74 speakers in 1993. Call Tracy Baker at (517) 336-5770 for information.

#### **Continuing Medical Education**

Physicians can choose from several conferences and many courses to earn relicensure credits or to learn more about a special topic. Clinical conferences include:

- the MSMS Annual Scientific Meeting Nov. 9-11 in Detroit.
- the Maternal and Perinatal Health Conference March 9-10 in Dearborn.

**Patient Advocacy** 

- Health System Reform
- Domestic Violence

#### **Physician Services**

- Medical Billing Services
- Medical Equipment Leasing Services

#### **Practice Management**

- More than 150 conferences and seminars
- In-Office Consultations

#### **Physician Representation**

• Legislative lobbying on a variety of issues

#### **Physician Well-Being**

• Unique seminars which help physicians and their families cope with stress.

behalf is what MSMS is all about.

Patient Advocacy

#### Physician Assisted Suicide

MSMS has developed "Effective Compassion for the Incurably Ill: Alternatives to Assisted Suicide," a seminar on how to manage symptoms of chronic illness and pain and on how to refer patients to pain specialists. Physicians will learn:

- about current state law.
- the legal scope of a durable power of attorney for health care and withdrawing or withholding life sustaining treatment.
- about options open to terminally ill patients.

The seminars have been held statewide in 1993 to ensure broad physician participation. Call the MSMS Office of Physician Education at (517) 336-5784 for details. Call the MSMS Department of Communications at (517) 336-5745 to order copies of the durable power of

Call the MSMS Office of Physician Education at (517) 336-5784 to learn more about MSMS physician education opportunities, or to be added to the seminars mailing list.

#### **Practice Management**

More than 150 conferences and seminars have been offered in 1993 to help physicians take care of business. They'll teach physicians how to comply with CLIA regulations, improve practice productivity and performance, how to handle electronic billing and how to build an effective office team. Coding clinics, seminars for medical billers and sessions on how to effectively handle workers' compensation claims will keep their office staff well-trained and working at peak efficiency. Call the MSMS Office of Physician Education at (517) 336-5784 to sign up.

Another MSMS practice management service physicians will find useful is an ongoing in-office consultation service for hands-on help with billing and coding problems. Call Joyce Nurenberg at (517) 336-5722 to learn about this management service or to schedule an appointment.

#### Physician Service Group, Inc.

This MSMS subsidiary provides physicians with medical billing services, a discount magazine subscription service, a car-leasing plan, medical equipment leasing services and a host of

Continued on following page

Continued from page 21

other helpful services. See accompanying article for more details.

#### **MSMS Group Insurance Trust**

This MSMS subsidiary administers MSMS-sponsored and endorsed insurance programs for physicians, including a Blue Cross Blue Shield of Michigan health benefits program, a Delta Dental program, disability income insurance and other services. Call GIT at 1-800-748-0195 for details.

#### POS/PHOS

To protect physician interests and to improve physician/hospital relations, MSMS created the Physician Organizations Committee. With the Committee's help, doctors around the state are creating physician organizations (POs) and physician hospital organizations (PHOs) to negotiate for physicians. Call Tom Plasman at (517) 336-5724 or Tom Wolff at (517) 336-5740 for details.

MSMS also created a new division, Physician Organization & Management Services (POMS), to provide physicians immersed in creating POs and PHOs expert consultant help. Call John Richards at (517) 336-7570 to learn more about POMS.

#### Physician Representation

State and federal lawmaking directly affects physicians and their practices. MSMS lobbies for physicians on legislative issues such as:

- health care reform legislation, including proposed single-payer and managed competition systems.
- scope of practice expansion for optometrists and chiropractors.
- prevention of mandatory HIV testing.
- public health legislation on immunizations, prenatal care and other areas.

That's why MSMS is working toward grassroots political involvement of physicians around the state. Get involved. Talk with Sandra Bitonti at (517) 336-5737 or Greg Aronin at (517) 336-5739.

MSMS also is working to prevent legislation mandating HIV testing and mandatory liability insurance.

MSMS continues its work at the federal level to ensure physicians' voices are heard in the national health care reform debate, and on legislative issues. Call Kevin Kelly at (517) 336-5743.

#### Physician Well-being

The practice of medicine brings with it stressors unlike those of other professions. The long hours of caring for patients, constant worry about lawsuits and the time involved in keeping up with constant changes can takes its toll on a physician and his or her family. Add to that the fact that a physician is used to taking care of others first. Recognizing that, MSMS developed a unique seminar to help physicians and their families cope with stress. The seminar will be conducted throughout 1993 in several locations around Michigan. Call Sherry Fent at (517) 336-5730 to register.

#### HCFA 1500 Forms Available...

The Michigan State Medical Society is pleased to announce a new product offered through its subsidiary, Abbott Press, Inc., **HCFA 1500 Forms.** 

These forms are available at \$38.75/1,000 for two-part carbonless, or \$12.15/1,000 for one-part forms, plus tax and shipping.

Please review the other products and services offered by Abbott Press:

- Newspaper/Magazine Advertisements and Consultations
- Design Services
- Durable Power of Attorney Forms and Brochures
- Printing packages designed specifically for physicians starting a new practice or relocating

If you would like information about any of the above products or services, or would like to order HCFA 1500 forms, please call Heidi VanOstran at (517) 336-7584, or fax to (517) 336-5797.





# Physician Service Group, Inc.

## offers the services you need to maintain a healthy practice

he most valuable commodity in any business—including medicine—is information.

But lack of time and external pressures make it difficult for physicians to gain the information they need to balance the business and patient care sides of their practice.

#### **PSG Helps Physicians**

That's where the Physician Service Group, Inc. (PSG) comes in. PSG helps you find the right service to solve your particular problem.

PSG was formed by the Michigan State Medical Society (MSMS). From the solo to group practitioner, PSG recognizes the importance of strong practice management. Ineffective management costs both you and your patients time and money. PSG helps you control these problems with insightful administrative programs and services.PSG simplifies and clarifies your organizational structure to make it more effective.

PSG looks for companies and services that take the physician seriously. General criteria are that the company is sound, has a solid record of longevity and continuing involvement with the medical community.

Once the company is a part of PSG, products and services can be offered to you at affordable costs because of the size and strength of the MSMS membership.

Here are some ways PSG works for your practice:

#### Health

#### Blue Cross Blue Shield of Michigan

Administered by the Michigan State Medical Society through the Group Insurance Trust (GIT). Plans created for physicians by physicians.

- Affordable rates statewide
- Group and Individual plans available to physicians, families and employees
- Optional prescription drug coverage
- Professional and courteous customer service representatives provided by GIT

#### Dental

#### **Delta Dental**

Sponsored by MSMS and administered by the Group Insurance Trust (GIT).

- Choice of Delta Traditional or PPO Plans
- 90% of Michigan dentists participate in the Traditional Plan

- Group continuous enrollment anytime during the year
- Available to physicians, family and employees

# **Life, Disability and Business Overhead Expense**

#### Stratton, Cheeseman, & Walsh, Inc.

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#### **Malpractice Insurance**

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A professional medical malpractice and liability insurance company created and governed by physicians.

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A medical equipment leasing program for today's healthcare environment.

- Special rates for MSMS members
- Pre-arranged line of credit
- Minimal capital investment

Continued on following page

Continued from page 23

#### **Discount Magazine Subscription Service**

A full service magazine subscription program for office reception room or personal use.

- Lowest available prices for MSMS members
- Hundreds of titles available.

#### **Members Long Distance Advantage**

A top quality long distance service designed exclusively for MSMS members.

- Save up to 25% on your long distance calls
- No cost to join
- Free customized calling card and 24 hour customer service

#### Randolph Medical Group

A medical/nonmedical supplies purchasing program intended to save physicians money.

- 25-50% off list price
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#### **Financial Services**

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#### **Diversified Financial Network**

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■ Nationwide electronic network of financial institutions

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Industry leader in on-line computer billing systems.

- Free practice analysis for MSMS members
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- Training provided on-site or in classroom
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A mobile communication service improving efficiency through accessibility.

- Largest continuous coverage area in Midwest
- 10% discount on home air time
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#### The Equitable

Retirement plans purposed to save the physician time and money.

- Pension, profit sharing, investment only plans
- Low set-up fees and record keeping costs

#### **MBNA** America

A Personal Gold Card designed to meet the needs of today's physicians.

- No first year annual fee
- \$15,000 credit line and competitive interest rates

#### **Physicians Leasing Company**

Automobile lease/purchase plan taking the hassles out of shopping for a car.

- Fleet incentives
- 12-60 month leases available
- Option to purchase at end of lease

#### **Select Communications**

An authorized Cellular One agent offering MSMS members discounts on a full line of cellular equipment.

- Competitive rates
- On-site installation, pick-up and delivery

#### **Additional Services**

#### **Association Administrative Services**

PSG helps state medical specialty organizations maintain membership records, process mailing lists, and collect dues. Account executives specifically assigned to a specialty organization, work with the society's officers and directors in fulfilling these administrative needs.

For more information on how PSG can help you, call MSMS Member Services at 517-336-7570.



# **Physicians' Legislative Network**

## Grassroots Political Action - MSMS Style

By Greg Aronin

embership is the strongest MSMS resource when it comes to effective government relations. The Michigan State Medical Society has developed a strong and extremely effective communications link, the Physicians' Legislative Network (PLN), The PLN provides crucial testimony on behalf of physicians statewide regarding issues of concern to medicine. Legislators respond more positively to their constituents than they do to the lobbyists in Lansing.

Members of the Physicians' Legislative Network (PLN) are informed of important health related issues. The PLN members receive a newsletter which describes issues in depth, concerning the physicians of our state. During times of political necessity, PLN members are contacted as expeditiously as possible either by phone, FAX or mail, and asked to contact their legislator to express the MSMS position on a specific issue.

MSMS also offers physicians the opportunity to familiarize themselves with the legislative process through the MSMS Doctor of the Day program. Doctors are invited to spend the day in Lansing attending legislative committee hearings, to observe the House and Senate sessions and to meet with their legislators. Physicians participating in the Doctor of the Day program have found it very informative and well worth the time spent in Lansing.

MSMS also conducts an annual government affairs day recently renamed the Capitol Check-Up program. The Capitol Check-Up will allow physicians and MSMS Alliance members from around Michigan to spend the day in Lansing interacting with legislators and becoming part of the political process.

For more information on these programs, call Greg Aronin, Chief, Legislative Affairs, at (517) 336-5741, or Donna LaGosh, Assistant for Political Action (517) 336-5788. Please join your colleagues and participate in MSMS Grassroots Political Action! 

Greg Aronin is chief of legislative affairs for MSMS.

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25



# Michigan Doctors' Political Action Committee

Heads into New Directions

By Donna LaGosh

s political action becomes increasingly crucial to the success of special interest groups, the Michigan Doctors' Political Action Committee (MDPAC) is moving forward in a new and progressive direction. Changes have been initiated in MDPAC due to the members' growing dissatisfaction with the old way of doing business. A retreat of MDPAC Board Members was held in February of 1993 to discuss a new focus for the future of MDPAC, or to dissolve the PAC all together. (See photo highlights beginning on this page.) A subcommittee was created and met three times over the summer to formulate recommendations for the entire MDPAC Board of Directors,

The outcome of these meetings is a return to grassroots activities to allow physicians and Alliance members to become directly involved with fund-raising, legislative contact, and membership recruitment. This hands-on approach to political action makes each active, well-informed physician or alliance member an influential voice to his/her legislator. Already during the past few months, several fundraisers and legislative meetings have been held around the state and were great successes due to the time and energy of enthusiastic physician and Alliance members.

which met on September 22, 1993.

As health care system reform looms in the near future, MDPAC must bring aboard new members to respond to the challenges that lie ahead. For more information on how you can become involved, please call Donna Welch LaGosh at 517/336-5788, or write MDPAC, PO Box 769, East Lansing, MI 48826-0769.



Photo highlights of the 1993 MDPAC Board Retreat





Top Photo: Krishna K. Sawhney, MD, outlined ideas generated at a breakout session on membership recruitment and retention.

Above: Fred E. Patterson, MD, an MDPAC member, expressed his ideas about the future of MDPAC.

Left: MDPAC Chair Mitchell A. Rinek, MD, led a discussion on the visibility of MDPAC at the MDPAC Board of Directors special retreat held last February in Frankenmuth.



Louis Zako, MD, an MDPAC member, summarized several suggestions made during the February MDPAC retreat.



As a young physician and a previous MDPAC leader, respectively, Tama Abel, MD, and Peter A. Duhamel, MD, expressed their views on the future direction of MDPAC.



Doctor Zako presented concluding remarks on the "Future of MDPAC."



There was great diversity in the ideas presented about the future of MDPAC. Shown expressing his views at the February MDPAC retreat is Inad Haddad, MD.



Richard Hausler, MD, shared his concerns regarding the impact that term limitations will have on the future of political action.



# The Michigan Physician's Communication Network (PCN)

A one-of-a-kind program for MSMS members

By Tracy Baker

rassroots activism is the buzz word of the '90s. At the Michigan State Medical Society, the Physician's Communication Network (PCN) is tapping into the power of grassroots members.

"The PCN is part of a strategy to involve all members in public relations and advocacy programs," explains MSMS President Gilbert B. Bluhm, MD. "We had so much success with the Physician Legislative Network program that we decided to apply the same principle to communications."

The concept of the PCN grew out of a vision of unified member involvement in issues that affect the public's welfare.

"There was a sense that if physicians were motivated on a local level to express their views this would go a long way in helping to educate the public and inform the legislature," explains W. Archibald Piper, MD, chairman of the MSMS Committee on Communications and Professional Relations.

Balanced against this grassroots strategy was a growing demand from physicians across the state for MSMS to keep them informed of the important issues confronting medicine. Physicians wanted to know what MSMS was doing, explains Doctor Piper, and how physicians could help in presenting "their side of the story" to the public.

MSMS set about meeting this dual demand by developing the PCN. A two-step process was established for initiating members into the program. First, physicians identified as potential spokespeople or leaders in medicine are selected to participate in media training workshops. These workshops are run by a public relations consultant who familiarizes the physicians with how the media functions. In four-hour-sessions a range of topics is covered including public speaking, how to be proactive with the local press, how to write letters to the editor, how to deflect aggressive or loaded questions and how to put your point across. In addition, the sessions include a mock interview which helps make physicians more comfortable with cameras and bright lights.

Twelve workshops have been held over the last two years at locations ranging from Detroit to Marquette. Approximately 200 physicians have been trained to deal with the press.

"Feedback from these workshops has been very positive," says Doctor Piper. Ken Rowe, MD, one of the attendees at the Marquette workshop found the training valuable. "I hope to use the excellent advice if called upon to represent MSMS," he says.

#### Training worthwhile

Most physicians have found the experience very worth-while-so worthwhile, in fact, that there have been repeated requests for longer sessions. The original intent of the workshops was to give physicians basic training, explains Doctor Piper. However, staff have discovered that many of the physicians have had some degree of exposure to the press, necessitating more advanced workshops. MSMS is planning two advanced workshops to be held in late November.

After the physicians have been trained to deal with the media they are invited to join the PCN. These members receive regular mailings keeping them updated on events and campaigns that are occurring in medicine and are called upon to assist in publicizing a variety of MSMS and AMA programs. "We are not training physicians to make them mouthpieces for MSMS activities," says Doctor Piper, "but rather to let them know what is going on at the state level so they can respond in an informed manner to local inquiries."

Physician assistance often takes the form of letters to the editor. Network members' names are also included in county speakers bureaus and state and local media contact lists.

MSMS has run several major campaigns which have drawn on the PCN for assistance in publicizing and educating the public. Two of the most successful were medical liability reform and support of anti-smoking legislation.

"The PCN is the only program of its kind in the nation," explains Doctor Piper, "and MSMS has found it very effective in informing local communities throughout the state about health issues."

Tracy Baker coordinates the PCN for MSMS.

# MSMS Alliance Targets Today for Tomorrow

By Jean Howard

arget Today for Tomorrow" is the membership theme for MSMS-A for this year. The newly-renamed MSMS Alliance is ready to move forward together with the Michigan State Medical Society to meet the challenges that medicine faces in the future.

We must remember that membership is the foundation of our organizations. We are looking at unprecedented changes in health care in the 1990s. In order to make sure that access to health care and quality of health care are at the top of these changes, we must join the Alliance or Society at all levels. There is strength in numbers and working together, we can make a difference.

We are a natural coalition! Medical Society members and physicians want to cultivate and improve relationships in the communities and with their colleagues. MSMS Alliance members have as their objective the best interests of the medical profession. The Alliance can be a forum for spouses to learn about the medical profession and its related problems. Alliance members can be another voice in the legislative arena, as just witnessed in the recent tort reform legislation.

#### Cooperation key

With the national emphasis on health care reform, it will be of mutual benefit to find ways to cooperate more closely. Individual society members can lend expertise to Alliance health programs and projects as advisors or participants.

The Medical Society benefits by having a resource of people power, experienced managers, and program planners with broad community contacts. Alliance members are great public relations experts who can deliver timely health education messages and be an integral part of the medical association programs.

Together, physicians and spouses can project a caring image that will strengthen community relationships and promote quality health education.

So, physicians, if there is a spouse in your house, please encourage him or her to join the Alliance and be a part of Medicine's largest support group. For Alliance membership information, contact your county medical society alliance or myself at 516 Birchwood Avenue, Traverse City, MI 49684.



Jean Howard is MSMS-A vice president and membership chair.

# YOCON® YOHIMBINE HCI

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug. 1.2 Also dizziness, headache, skin flushing reported when used orally. 1.3

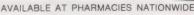
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence. 1.3.4 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks. 3

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References

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- 4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Health Data Research Julie Lester

**Health Education Foundation**Dawn Reha

HMOs/PPOs Mary Anne Ford

**Hospital Medical Staff Relations** Tom Plasman **International Medical Graduates**Betty McNerney

**Judicial Commission**Sherry Fent

**State legislation** Sandra Bitonti

Maternal Health Conference Sarah Cressman

Media Relations David Fox

Medicaid Tom Wolff

Medical Assistants Caroline Kimmel

Medical Billing Consulting Joyce Nurenberg

Medical Ethics Tracy Baker

Medical Students Deborah Zannoth

Medicare Payment Reform Julie Lester

**Medigram** Claudia Skutar

Viola Heins

Viola Heins

Member Benefits/Recruitment

Deborah Zannoth

Michigan Allergy Society

Michigan Association of Medical Education Viola Heins

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Michigan Dermatological Society Dawn Reha

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Michigan Medical Group Managers Association Caroline Kimmel

Michigan Medicine (Journal) Advertising/Editorial Betty McNerney

Michigan Society of Anesthesiologists Caroline Kimmel

Michigan Society of Internal Medicine \( \) Caroline Kimmel

Michigan Society of General Surgeons

Caroline Kimmel

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MSMS House of Delegates Donna Farougi

MSMS Travel Programs Donna Farougi

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Physicians Contracting Assistance Tom Wolff

Physicians Executive Organization Tom Plasman Physician Hospital Organizations Tom Plasman

Physicians Recovery Network Tom Wolff

Physicians Review Organization of Michigan, Inc.
Jim Tarrant

Physicians Legislative Network Greg Aronin

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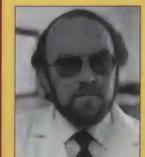
# MICHIGAN STATE MEDICAL SOCIETY AIDS PROVIDER EDUCATION PROJECT



Tammu Boccomino HIV Positive Son diagnosed with AIDS at age 18 months

A random blood test performed after the birth of her second child six years ago revealed that Tammy Boccomino of Warren was HIV-positive. The source? Her first husband, an IV drug user. Frantic, Tammy had her two-year-old son tested. He was negative. So was her second husband. It was too soon to tell about her newborn baby. Sadly, by the time he reached 18 months, it was clear he had full-blown AIDS. Her son, now six, is still hanging in there. Tammy, too, is well. Her goal is threefold: to educate the public on how to prevent infection; to erase the stigma attached to AIDS; and to help people with AIDS, and families who have loved ones with AIDS, live out their lives with dignity. "I would like to continue to be an AIDS crusader for as long as I am able."

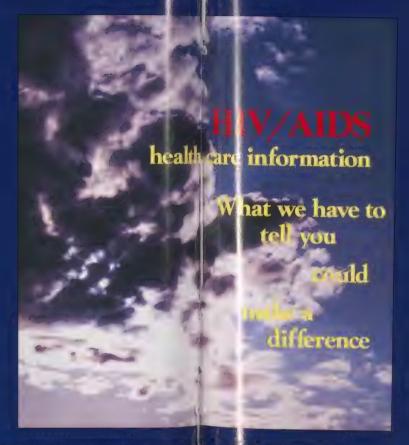
For more information contact: AIDS Provider Education Project Michigan State Medical Society 120 W. Saginaw St



Peter G. Gulick, DO Assistant Professor Department of Internal Medicine, Michigan State University

Doctor Gulick has been a member of the MSMS AIDS Speaker's Bureau since its inception. As an assistant professor of medicine for the College of Osteopathic Medicine and the College of Human Medicine at MSU, Doctor Gulick has devoted countless hours to speaking about HIV/AIDS to health care professionals and the general public.

"It's a good way to discuss current information (about HIV/AIDS) to health care professionals and the public...that's the main thing. I have seen many positive results.



available to speak to groups on a variety of W related issues. Available speakers include doctors, nurses, social workers, attorneys, in tion control practitioners and people who are HIV +. The HIV/AIDS Speakers Bureau is put the MSMS AIDS Provider Education Project.

HIV. This includes substance abuse counselors HIV testing counselors, school nurses, hospital staffs and nursing home personnel.

The MSMS HIV/AIDS Speakers Bureaus resource comprised of over 150 individuals The Speakers Bureau is available to any with care audiences requesting information on



Ruth Anne Rue, RN Infection Control Consultant Preferred Metpath Labs

Manager of Saginaw Community Hospital Infection Control for nearly 10 years, Ruth Anne Rye now serves as an infection control consultant for Preferred/Metpath Labs. Long interested in AIDS prevention, Ruth Anne has devoted numerous hours to educating allied health professionals on risk awareness and reduction. "I tru to get them to think about HIV/AIDS in terms of their own personal lives. More people are at risk of contracting AIDS in their personal lives than they are in the workplace."

Are there still misconceptions about AIDS transmission? Absolutely, says Ruth Anne. "A lot of people think we've covered the bases, but that's not true. I still get the same questions (about HIV/ AIDS) I got five years ago. The more things change, the more things stay the same."



Harry L. Simpson, Public Health Consultant South Eastern Michigan Health Association (SEMHA) in conjunction with MDPH

A public health consultant since 1989, Harry Simpson is actively involved in AIDS prevention. As a member of the MSMS AIDS Speaker's Bureau, Harry speaks to a variety of health care professionals and the lay public. His target audiences include substance users, prison immates and adolescents. He praises the Speaker's Bureau because it allows groups and agencies to have access to highly-trained speakers at no cost. "This is the greatest advantage because many groups and agencies simply don't have the funds."

East Lansing, MI 48823

517-337-1351



and intervention by health care professionals. gan State Medical Society (MSMS) recently announced a new program aimed at reducing domestic violence through improved detection 40-member coalition organized by the Michi-

ability to recognize and treat patients who may be detailing how health professionals can improve their victims of spouse abuse. Centerpiece of the program is a 70-page handbook

county-by-county list of shelters is included. documentation and intervention. All Michigan laws Abuse," covers how to talk to patients, diagnosis, pertaining to domestic violence are reviewed and a The handbook, "Reach Out: Intervening in Partner

women, and accounts for more than half of all female radiologist and spokesman for the MSMS Task Force on Family Violence. homicides," said Thomas C. Payne, MD, a Lansing "Battering is the single major cause of injury to

will be abused by a current or former partner at one quarter of the women in the United States have been or economic groups," Doctor Payne said. "Nearly onetime during their lives. "This problem encompasses all ages, all races and all

> vance of Domestic Violence Awareness Month in Octo-Release of the handbook coincided with the obser-

care professionals for help with this problem; and to prevalence of domestic violence and to give them the physicians and other health professionals about the impact on the problems of domestic violence. know they may look to their physician and other health information they need to respond to it; to let patients unite the professional community for the maximum The goal of the new program is three-fold; to educate

system, including medical, legal, correctional and social family violence to occur," said The Honorable Carolyn services to begin to change the attitudes that allow for players in addressing the problem immediately, and in Stell, an Ingham County Circuit Court judge and memchanging attitudes. ber of the Task Force. "Medical personnel are key "It will require the cooperation of all elements of the

gan State Police Prevention Services Section, agrees. Lt. Michael Moyes, commanding officer of the Michi

anticipate improved services to victims of domestic bringing together a coalition of professionals and volunis an opportunity for us to accomplish something." violence, child abuse and neglect and elder abuse. This "Subsequent to the Task Force's release of this book, I teers to address family violence issues," Lt. Moyes said "Law enforcement owes MSMS a debt of gratitude for

sustain serious physical, emotional and spiritual injury thousands of Michigan families are affected. Victims partment of Social Services, pointed out that each year Prevention and Treatment Board of the Michigan Deshe said. Kate Young, acting director of the Domestic Violence

killed in domestic homicides in Michigan. death," Young said. "In 1992, at least 43 people were "Unfortunately, domestic violence can result in

religious communities and the medical arena must work enforcement, the courts, mental health services, schools, said. "Those working in victim service agencies, law together to ensure the safety of victims and require accountability from domestic assailants. "These human tragedies can be prevented," Young

5745. grams. For more information, call Judy Marr at 517-336 treating abuse victims. The effort continues, with the emphasis on helping hospitals establish treatment proeducate physicians and others about the complexities of MSMS has sponsored conferences and seminars to In the 18 months since the Task Force was organized

copies are \$15 with a discount for multiple copies. Partner Abuse," call MSMS at 517-336-5745. Single To obtain copies of "Reach Out: Intervening in

# Task Force on Family Violence Members of the MSMS

DOMES

Kent County Medical Society
Lenawee County Medical Society Great Lakes Pediatric Association Flint Coalition Against Domestic Violence Citizens for Better Care Eaton County Department of Social Services American College of Obstetricians/Gynecologists BOC-FAD Medical Department House Republican Staff Henry Ford Hospital -amily Services Agency Booth Newspapers American Association Retired Persons Lansing

Michigan Department of Public Health Michigan Committee for Prevention of Child Abuse Michigan Academy of Physician Assistants Michigan Association - Children's Alliances Michigan Association of Osteopathic Physicians & Medical Management Systems Surgeons

Macomb County Medical Society Mary Free Bed Hospital

Michigan News Association
Michigan Prosecuting Attorneys' Association
Michigan Psychoanalytic Society Michigan State Medical Society Alliance Michigan Michigan Judges Association Michigan Elementary & Middle School Principals Michigan Department of Social Services Michigan Education Association Michigan Hospital Association Michigan Family Forum

Oakland County Medical Society
Office of Services to Aging National Organization for Womer Michigan State University College of Osteopathic Providence Hospital New Detroit, Inc. Medicine

State Bar of Michigan
Turning Point, Mt. Clemens
Washtenaw County Medical Society
Wayne County Medical Society
Wayne State University College of Nursing

# **Facts About Domestic** olence in Michigan

- Domestic abuse victimizations reported by Michigan Law 1989 and 1992 from 19,416 to 29,891. Enforcement Agencies increased by 54 percent between
- In 1992, there was one domestic homicide every eight days
- In than 50 percent of those served were children. tion assistance from domestic violence programs. More 1992, 13,376 Michigan families received crisis interven-
- Fewer than three out of 10 victims reported that their assault. assailants had ever been arrested for a previous domestic
- More than three out of five victims reported that the police that their assailant had been arrested. had been contacted; yet fewer than one out of five reported
- Michigan domestic violence programs reported that 44 burns, bruises. reported injuries to the head; 80 percent reported cuts a knife; 69 percent reported their partner had threatened against them; 25 percent reported their partner had used physically abused more than three-to-four times per year, 21 percent reported that their partner had used a gun one or more times a week; 76 percent reported being to kill them; 59 percent reported being choked; 37 percent percent of victims reported being physically abused at least percent reported that their partner had used a gun

Source: Michigan Department of Social Services

# First Lady endorses handbook

nizations of the Michigan State Medical Society Forum on parties on domestic abuse published by participating orgareference for health care professionals and other interested Family Violence. "Reach Out: Intervening in Partner Abuse," a statewide I am pleased and honored to write a letter endorsing

physicians, patients, and other interested parties to use violence and how to approach women suspected of being valuable information about how to recognize domestic when dealing with domestic violence victims. Included is This publication is an outstanding resource tool for

> refuge or seek additional help. domestic violence shelters where victims of violence can find battered or emotionally abused, as well as a list of county

counseling will greatly enhance state and local efforts to provide safety, in combating violence in the family. I believe this handbook I commend all associated with this project for their efforts and security to victims of domestic violence.

effects of domestic violence and give thousands of Michigan inroads toward reducing or eliminating the devastating citizens a new lease on life. I know that with a coordinated effort, we can make great

Michelle Engler

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Michigan State Medical Society
Group Insurance Trust
120 W. Saginaw
P.O. Box 950
East Lansing, Michigan 48826-0950
(800) 748-0195





# MSMS Reimbursement Roundup

By Joyce Nurenberg

MSMS REIMBURSEMENT OMBUDSMAN

# Medicare's position on limiting charges when billing NOC codes

When billing Medicare for a service for which there is no CPT or HCPCS code, the service shoud be coded under the appropriate non-otherwise classified (NOC) procedure code.

If the charge exceeds 115 percent of the determined approved amount, a limiting charge exception report will be sent to the physician. The physician can either challenge the allowance through the informal review process or accept what Medicare has determined to be the limiting charge and refund the beneficiary any amount that have been charged in excess. The beneficiary will receive notice via the explanation of benefits (EOMB).

Remember to submit supportive documentation with claims for NOC codes.

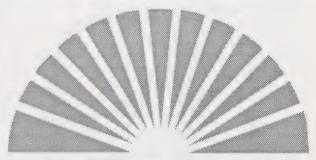
#### Conditions upon which physician offices must submit claims to Medicare when Medicare is secondary to another health plan

If a beneficiary has Medicare secondary to a primary insurance, you are not required by law to submit the claim to the primary payer. If your office receives a determination on the claim directly from the primary payer, you are responsible for submitting a claim to Medicare for secondary payment. Likewise, if the beneficiary receives the determination but chooses to forward the primary payer information to the your office, you must submit the secondary claim to Medicare for the beneficiary in accordance with the mandatory claims filing requirement. (Medicare Carrier Manual 3041.B)

#### **Medicare/BCBSM Group Practice Definition**

According to Provider Registration at BCBSM, a group practice is defined as a practice of two or more physicians set up in the name and tax identification (ID) of the group. The tax ID of a group and that of an individual physician should never be the same.

For groups that bill under a group Provider Identification Number (PIN), then a patient is a new patient only if the performing physician, or any of the group members of the same specialty, have not seen the patient in the last three years.



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## GILBERT B. BLUHM, MD

"I've always thought it was important for physicians to be a part of organized medicine."

By David K. Fox

single word sums up this leading physician: devotion. Devotion to his patients, his research, to organized medicine, to his church and community, and yes, even a little to golf.

It was back in 1946, his senior year in Freelandville (Indiana) High School, when his basketball coach and advisor, Red Ritterskamp, asked the life-determining question of Gil Bluhm.

"The war's over. You weren't drafted. You're going to college next year. So what are you going to do?" Ritterskamp wanted to know.

"I think I want to be an engineer, I'm pretty good at math," was the tenuous reply. "But my dad thinks I should be a lawyer."

"Well, what do *you* want to do?" the coach demanded.

"Honestly, I always thought I'd like to be a physician," young Bluhm responded. There were numerous physicians on his mother's side of the family and he vividly remembered the doctor who saved his life with a painful shot of "horse serum" to cure his double pneumonia a decade earlier. "I think it would be a good thing to do to help people."

Coach Ritterskamp agreed and encouraged Gil Bluhm into a profession where he has devoted the last four decades to helping people.

#### The early years

In 1953, after three years of undergraduate work at Indiana University and another four in medical school there, Doctor Bluhm, along with his new bride, Barbara, and their first of four daughters, set off to an internship at Lafayette, Indiana. He and Barbara met in a quantitative chemistry class as she pursued a medical technology degree. They married in 1951.

In the early 1950s, the Korean War was heating up. In mid-October, 1954, Doctor Bluhm heard from his nearly gleeful local draft board which had been frustrated at being unable to furnish a physician during World War II. But during his 30-month tour of duty, Doctor Bluhm saw no wounded soldiers. He spent the duration as a Navy physician landlocked at a desolate, top

secret research outpost in Pocatella, Idaho, where he was an occupational health and safety officer. He also watched over the crew of the first atomic powered submarine, the Nautilus.

"They shipped in sea water and ran the sub's nuclear engine at top speed 24-hours a day for a year," Doctor Bluhm said. "We analyzed the water to make sure it was not putting out atomic waste."

At the end of his tour, the Navy asked Doctor Bluhm to stay on. But despite the "best pay we had ever had" and the respect he was accorded as a lieutenant commander, he declined.

"I thought in a nuclear Navy I wouldn't get to work with patients enough," Doctor Bluhm said. He stayed in the Naval Reserves until 1964.

Doctor Bluhm was able to get back to patient care and eventually into research during his residency in a new subspecialty of medicine-rheumatology -at Henry Ford Hospital from 1958 to 1960. His plan was to return to Indiana afterward, but the hospital

asked him to stay on and join the "arthritis" staff. At the time, Doctor Bluhm was one of only 350 rheumatologists in the country. In 1986, he was recognized as one of the Founding Fellows of the American College of Rheumatology.

Doctor Bluhm's interest in rheumatology goes back to his childhood. He remembers a neighbor who was chair-ridden with arthritis and whenever she had to be moved, she screamed in agony.

"Are they being mean to her?" the compassionate young man asked his mother.

"Not much was known about inflammation of the joints in those days," Doctor Bluhm said. "This was a wonderful chance to do clinical research."

Doctor Bluhm took over the rheumatology research lab at Henry Ford Hospital and began a teaching program in rheumatology. He has since lectured throughout the United States, all across Europe and in Canada.

"I've always enjoyed teaching and lecturing," Doctor Bluhm said. The position at Henry Ford Hospital was perfect for him because he was able to do research and be active in direct patient care.

#### A commitment to organized medicine

Doctor Bluhm's devotion to his specialty and his patients also is reflected in the time and energy he gives to other organizations. He has been a member of the National Arthritis Foundation, Michigan Chapter, for more than 30 years, serving on its board of trustees most of that time and as president and chair in 1982-86. He was also active in the National Arthritis Foundation until November 1991 when he completed six years on its Board of Trustees.

Doctor Bluhm's devotion to organized medicine began early in his career. He joined the local county medical society during his internship in Lafayette, Indiana, "to learn about the practice of medicine outside of the hospital." He also joined because the hospital where he was serving encouraged a locum tenens at that time and required membership in organized medicine to be on the staff.

"That's how I got started and I've never relinquished it," Doctor Bluhm said. "I've always thought it was important for physicians to be a part of organized medicine." When he settled in Michigan, he transferred this membership to the Wayne County Medical Society, the Michigan State Medical Society and the American Medical Association.

In the 1960s and 1970s, Doctor Bluhm was active in the internal governance system of the Henry Ford Hospital. However, it was in the early 1970s, during the medical liability crisis created by insurance companies deserting Michigan physicians, that Doctor Bluhm realized medicine was about to face some major changes. By the late '70s, Doctor Bluhm was not as busy with his research, teaching and lecturing, and he began looking for a way to become more involved in organized medicine.

At that time, the energetic activist Carl Gagliardi, MD, was president of WCMS.

"He sent everyone a simple sheet of paper with 20 committees listed on it, asking on which of them you wanted to become involved," Doctor Bluhm said. Doctor Bluhm was interested in serving either on the Wm. Beaumont Lecture Committee or on the editorial board of *Detroit Medical News*. He soon received a letter from Doctor Gagliardi stating that he had been appointed to both.

Doctor Bluhm became increasingly involved and by 1984 he was elected secretary of the WCMS board. He served for two one-year terms. In 1986 he was voted president-elect and then served as president in 1987-88.

During his leadership roles at WCMS, throughout the liability crisis, throughout RBRVS development and implementation, Doctor Bluhm's over-

riding message was to remain unified as a profession to maintain a strong voice.

"It's still my message today as we deal with health system reform," Doctor Bluhm said. "We must remain united and continue to be advocates for our patients."

#### A devotion to public health

As MSMS president, Doctor Bluhm has devoted his presidency to promoting awareness and the need for improved public health, focusing on preventive aspects of youth to develop healthy lifestyles and avoid violence, drug and alcohol abuse.

In addition to his broad professional commitments and his busy schedule as MSMS president, Doctor Bluhm and Barbara are active in their church, the First Baptist Church of Detroit in Southfield. He has served as chair of their Board of Trustees, as superintendent of the Sunday school and chair of the building committee when a new sanctuary was built. Both sing in the choir.

The Bluhm's have been married 42 years, ever since his second year of medical school at Indiana University. They've been devoted partners though good times and difficult times.

"Looking back, choices have not always been perfect," Doctor Bluhm said, "but Barbara always has been very supportive of my activities. Even with some difficult times, we would do it the same way all over again."

For the past 18 years, the Bluhms have been partners in another endeavor: golf. They frequent the fairways at the Red Run Golf Course in Royal Oak. But, according to Doctor Bluhm, not frequent enough.

"We've been in Michigan 35 years," said the transplanted Hoosier." We love it here. The people we've met. The colleagues I've worked with. It's been wonderful."

Dave Fox is chief of media relations for MSMS.

# Coming Out Of The Dark

The Physicians Recovery Network sponsored by the Michigan State Medical Society and the Michigan Association of Osteopathic Physicians & Surgeons takes a confidential and non disciplinary approach. It helps Michigan physicians with substance abuse and mental health problems... addiction, marital/family conflicts, psychiatric illness, organic impairment, physical handicap .... If you or someone you know is experiencing these or other problems, we can help find the solution. Call us.

Services of the MSMS/MAOPS Physicians Recovery Network are available to all Michigan physicians, and their families. The Network is NON DISCIPLINARY and information is kept CONFIDENTIAL. If you, a colleague, or family member need our services call (313) 391-1267 or (517) 337-1351.



# **Impaired Physicians: New Law Stresses** "Treatment Rather Than Punishment"

Ralph D. Ward

sk the general public about professions associated with substance abuse, and the practice of medicine is sure to be mentioned. Pressured physicians relieving the stress with one too many. All those drug samples, ready at hand....

Nonsense, according to Thomas L. Haynes, MD. "The rate of addiction is no greater lamong health care professionals] than for the general population." Doctor Haynes is in a position to know. He's founder of West Michigan Addiction Consultants PC, and an expert on substance abuse and

addiction among health care professionals. Despite the obvious and unquestioned dangers an impaired physician can represent, Doctor Haynes also notes that actual patient injury or neglect is rare. "The risk is not as great as people fear."

Yet any risk to patients from a drug or alcohol abusing or addicted physician is too much risk. Unfortunately, options for dealing with the problem have been few. Fellow practitioners may be aware that a colleague has a problem. Family members may grow concerned. Even the physician may realize, deep inside, that he or she is losing control. Yet there have been strong disincentives to seeking or encouraging treatment. Michigan law has offered no option other than disciplinary action, which could well

mean a loss of license. Such a rigid, formal policy left concerned friends with few choices other than ignoring the problem or taking the risk of destroying a career. Now, however, a new law, developed with input from MSMS, offers a third alternative: confidential, non-disciplinary treatment.

#### MSMS involvement

MSMS historically has faced up to the problem of physician substance abuse, offering a number of effective programs. The MSMS Committee to Assist Impaired Physicians dates back to 1980. Robert Niccolini, MD, clinical associate professor of psychiatry at the Wayne State University of Medicine and chair of the committee for the past two

years, observes that, although the group has pursued a number of agendas over the years, the overriding goal has remained the same. "The main purpose has been to aid in assessment and intervention for impaired physicians, and to develop recommendations for treatment," says Doctor Niccolini, who has been a member of the committee for the past eight years. The committee has worked in other ways to support impaired physicians, and to spread awareness of the problem of physician impairment. Members are available to provide educational programs on the problem for hospi-

> tals, and also will give talks on physician impairment at county medical society and hospital staff meetings. In the works is a library of education material.

The group works in close conjunction with the Michigan Association of Osteopathic Physicians and Surgeons and its members. "We've also, through the years, done clinical work, and monitoring through recovery, assessment, and help with reentry. In recent years, though, the more clinical aspects have been handled by the MSMS Physician's Recovery Network."

The Network, which develops treatment and recovery options for impaired physicians, is another MSMS service, and has built a solid body of knowledge on how addiction

effects the medical population. Doctor Haynes, who formerly headed the PRN, has found that although the numbers are similar, the process of addiction among the medical profession differs from that in the general population. "Even though the disease has the same incidence, the way it is expressed is different." Drugs are more likely to be pharmaceuticals, keyed to what's available in the physician's specialty area. In the private office environment drug samples, such as Vicodin or the latest benzodiazapene, are a temptation. Anesthesiologists are more likely to misuse short-acting narcotic analgesics, such as Fentanyls.

Doctor Haynes also sees differences in how the process of addiction proceeds. "The physician is in a position where

Continued on following page

It should be emphasized that the new law requires physicians who have 'reasonable cause' to suspect a colleague has an abuse problem to report the physician involved...Those making such reports are 'held harmless' from any future civil or criminal action for filing the report. 99

Continued from page 41

he has access. Perhaps one day he is suffering from a headache. Some samples are available, and he decides to give them a try. The headache goes away, and not only that, he feels pretty good, too. This creates a reinforcing behavior. The next time he has a headache, he repeats the procedure,

#### **PRN** wants to expand

The MSMS Physician's Recovery Network is looking for minorities and women interested in becoming a part of the network. Those interested are encouraged to contact Tom Wolff at MSMS (517) 336-5740.

maybe even increasing the dosage. Of course, not every physician increases the dosage, but if the user is predisposed to addiction, he will take the drugs in anticipation of pain. This is where he starts to lose control. The us-

age increases, and becomes a daily habit. It becomes the top priority, and he starts to neglect other interests. It affects his work and his home life."

As noted earlier, colleagues and family have had few options when the disease progresses to this stage. "There is a problem with talking about this in the profession," according to Doctor Niccolini. "For many years this has been a hidden problem. There has been a tendency for doctors to be very concerned with confidentiality." Now, a new law has been passed that will not only offer a treatment track for impaired physicians, but will provide a practical way for them to preserve both their license and confidentiality.

Several years ago, Doctor Niccolini and members of the MSMS Committee to Assist Impaired Physicians came into contact with State Representative David Gubow, who had drafted legislation to deal with the problem. "Rep. Gubow had proposed legislation," says Doctor Niccolini, "and we recognized that it should include the experience and opinions of those in the field." The MSMS committee set up a subcommittee to work with Rep. Gubow and officials of the Michigan Department of Licensing and Regulation on recommendations. The subcommittee, consisting of Doctors Haynes, Niccolini, Michael Boyle, DO, and two members from the Department of Licensing and Regulation, spent over a year working on the package, drafting language that would meet the public's need for straight physicians while assuring a realistic, humane path toward recovery for physicians who were addicted.

#### How the new law works

The result was House Bill 4076, the Health Practitioners Recovery Act. The legislation "is another tool for dealing with impaired physicians," according to Doctor Haynes. It establishes a framework that allows the physician to seek help while avoiding licensing sanctions, according to Doctor Haynes. First, the law calls for establishment of a Health Professional Recovery Committee within the Michigan Department of Commerce. Each licensing board, including the Michigan Board of Medicine, will appoint a member to

the committee. In addition, the Director of the Michigan Department of Commerce will appoint two public members, at least one of whom must have specialized training or experience in the treatment of persons with addictive behavior.

This committee will design a confidential treatment program for physicians that lies outside the licensing process. They will plan all aspects of the program, including a monitoring system, and set criteria for the identification, assessment and treatment of practitioners involved. The committee must also design a mechanism to assure follow-up treatment and evaluation of the recovering physician. Finally, the committee will select a private outside consultant specializing in the treatment of addiction to help it set up and administer the program.

The consultant will do most of the casework involved in physician treatment, and act as the physician "conduit" into the system. If a physician seeks treatment, or another party reports a suspected impairment case, the consultant will review the case to determine whether the physician truly does have a substance abuse problem. Other factors also are considered at this stage. What treatment regimen would be most effective? Does the physician pose a danger to patients? How much, if any, limitation should be placed on his practice? Does he/she have a prior history of substance abuse? How will the recovery process be monitored?

The consultant then reports back to the committee, which decides whether to accept the physician for treatment. Before acceptance, the physician must acknowledge his or her impairment, voluntarily limit the scope of their practice (if required), and agree to participate in an approved

treatment plan. If the physician will not accept treatment, or accepts treatment and fails, the committee must report the practitioner to the Department of Commerce for appropriate licensing discipline. However, if the committee decides

# MSMS is seeking information on treatment programs

MSMS is in the process of compiling an up-to-date list of treatment programs for impaired physicians. Physicians aware of treatment programs in their communities are encouraged to contact Tom Wolff at MSMS.

that the physician has successfully completed a treatment plan, all records are destroyed and the physician's involvement remains confidential. The case remains open for five years, at which time the recovery is considered complete. "If they do well for five years, the case never goes to the board [of licensure]," observes Doctor Haynes. "Everything is kept very confidential. The records are not even subject to subpoena." In short, the physician gets a chance for treatment that allows him to keep his license and reputation intact.

If the process of addiction for physicians (especially involving illegal drugs) differs from that of the general population, so does the process of recovery. According to

Doctor Niccolini, "we've found that when substance abuse is involved, other areas of the physician's life, such as the family, suffer before patient care. The practice is usually the last to suffer." This ability to hold to professional expertise to the end protects patients, but could help make recovery more complicated. "The recovery process is more difficult for health care practitioners," observes Doctor Haynes. "They bring in a certain feeling of invulnerability, of infallibility. They're more sophisticated in denial, too, finding very clever, informed ways around the assessment process." The risk of relapse is also higher, since the physician must reenter the world of prescription drugs as a matter of course.

#### No nonsense choices

MSMS worked closely with State Representative Gubow during the drafting process for the law, including a careful review by MSMS legal counsel. "This was not a law foisted upon us," says Doctor Niccolini. "We had active participation from its inception, and we're pretty pleased with the final result." Still, the law offers no-nonsense choices to the addicted physician: get well or face disciplinary procedures. "This procedure is a diversionary track, but it won't help the doctor who has done illegal things," notes Doctor Niccolini. "It would be devastating to the profession if the public thought this law was written to protect bad physicians." Doctor Haynes agrees that the new law is compassionate,

but tough. "They generally get one chance at treatment. If they relapse the sanctions fall into place." Still, Doctor Haynes notes that there are two types of relapse; one is a brief, recovery-related relapse. This is accounted for in the recovery process. A longer-term, malignant sort of relapse requires further treatment or sanctions.

#### A popular law

The law, which will go into effect on April 1, 1994, has proven popular with physicians from all specialties. "We've received no resistance from any quarter," notes Doctor Haynes. It should be emphasized that the new law requires physicians who have "reasonable cause" to suspect a colleague has an abuse problem to report the physician involved. (There is an exception for physicians involved in a bona fide physician/patient situation with the suspect practitioner). Those making such reports are "held harmless" from any future civil or criminal action for filing the report. Moreover, a physician who fails to make a required report cannot be successfully sued for damages.

Will the new impaired health law really do the job? "I'm very supportive of the law," says Doctor Haynes. "It provides a compassionate method for dealing with the problem. Diseases deserve treatment rather than punishment."

Ralph Ward is a Lansing-based freelance writer.

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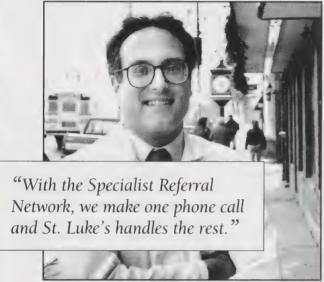
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# Judicial Commission & Risk Management

Commission routinely receives questions, complaints about access to medical records

By Helen Fordham

y doctor won't let me have my medical records, Mary Smith wailed plaintively into the phone. His employees are rude, too, she added, and they make me wait for ages to see the doctor.

Mary Smith is not alone in her complaints about physicians. Nor are her lamentations particularly unique. The most frequent complaints the Michigan State Medical Society receives about physicians is that fees are too high, patients can't get their medical records and that physician office staffs are rude and disrespectful.

"MSMS receives about 25 calls a week from patients unhappy with the way they have been treated by their physician and his or her staff," says Sherry Fent, manager, MSMS Department of Administration and Physician Education. "Most are straightforward complaints but they can lead to larger problems, including litigation, if they are not dealt with promptly," she explains.

#### Handling complaints can be difficult

Although the Board of Medicine enforces medical law in Michigan in accordance with the Public Health Code, dealing with complaints about physicians can be difficult since aspects of their conduct are regulated by ethics rather than laws. "Every physician is expected to behave in an ethical manner," explains George Morley, MD, chairman of the MSMS Judicial Commission. "Yet there is no way to enforce ethical behavior."

One medical society mechanism for monitoring physician behavior and dealing with complaints is the MSMS Judicial Commission and the ethics committees of the various county medical societies. The commission and committees have jurisdiction over matters relating to professional ethics grievances, mediation, discipline of members and professional conduct.

"The Judicial Commission and the ethics committees not only investigate complaints lodged by fellow physicians but also afford the public an informal means of making known to the profession any alleged grievance arising from the physician-patient relationship," explains Doctor Morley. He added the Commission provides an opportunity for patients to resolve disputes with physicians without resorting to litigation.

The standard procedure for complaints is to ascertain that the physician is a member of the medical society and then refer the complaint to the county level. The complaint is investigated there. If the physician is found to have acted unethically, consequences can range from a reprimand to expulsion from the medical society. "The Commission has no legal power to penalize unethical behavior," say Doctor Morley, "but it can make recommendations to the Board of Medicine that a license be revoked." If either the patient or physician is unhappy with the outcome, then the issue may be referred back to MSMS Judicial Commission for further investigation.

Continued on following page

#### **MSMS Judicial Commission**

The MSMS Judicial Commission has general jurisdiction in matters relating to professional ethics, grievances, mediation, discipline of members and professional conduct generally. The following physicians, elected by voting members of the Society, currently serve on the Commission:

Vincent J. Gallant, MD

Detroit

Edwin H. Gullekson, MD, Chairman, Flint

William A. Harrity, MD
Warren

Cecil R. Jonas, MD Southfield

Myron M. LaBan, MD Royal Oak

Gerald H. Mandell, MD

Detroit

Gary M. Mikel, MD

Calumet

george W. Morley, MD

Ann Arbor

William E. Sprague, MD Grand Rapids

James W. Wilkins, MD

Jackson

Richard D. Weber, Advisor, Kerr, Russell & Weber, *Detroit*  Continued from page 45

Complaints MSMS receives about physicians range from sexual misconduct to negligence, both of which violate the law. But reports of these more egregious cases are infrequent, says Fent.

"We do receive a number of calls from patients complaining about physicians' hygiene practices," says Fent, adding that many patients are concerned with the spread of AIDs and other communicable diseases.

By far the most common complaint MSMS receives from the public about physicians, according to Fent, concerns the physicians' refusal to release a patient's medical record, particularly if there is an outstanding bill.

According to the AMA *Current Opinions* of the AMA Council on Ethical and Judicial Affairs, it is considered unethical to withhold a patient's record because of an outstanding bill. What's more, in Michigan it is against the

law for a physician to deny a patient access to their records, except when the records relate to mental health. The law states that although the paper the medical records are written on belongs to the physician the patient has legal access to the information.

Yet some physicians do not appear to know this, says Fent. "Not giving patients access to their records can leave a physician open to liabil-

Continued on page 48

#### **Ownership of Medical Records**

The following was ruled by the Attorney General of Michigan on May 30, 1978, opinion no. 5125:

- 1. The patient information contained in the medical records is the patient's property.
  - a. The patient has a right to access this information and a right to obtain a copy of the information within the record.
  - b. The health care provider may implement policies for patient viewing of records which do not interfere with the normal routine.
- 2. The health care provider owns the "hard copy" original.
  - a. The health care provider will determine forms and information to be placed in the record.
    - i. MCL 333.20175 requires the health care provider maintain a full and complete record for each patient.



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Continued from page 46

ity," she explains. "If a patient does not receive correct care because a physician withholds records, then there is a risk they will be held responsible for any unfavorable outcomes."

"It is much simpler to write off the amount rather than risk a several hundred thousand dollar law suit," advises Julie Smith, chief of risk management for MSMS.

A registered RN with several years of experience as a liability manager, Smith holds seminars around the state on how to reduce physician liability. She hears complaints about office procedure from the physicians' perspective and she recommends that the small battles with patients over records are not worth the ill will they create.

Another common complaint Fent hears is that physicians' office staffs are rude. Patients call if they feel they have been treated discourteously and not listened to, she says.

Smith says the importance of office staff in averting complaints and possible litigation cannot be understated. "Office staff impact how patients feel about their health care," she says. Patients spend 70 percent of their time in a physician's office with the staff, so they develop their impression of the doctor from how the staff treat them. "If a patient is treated well and their questions are answered adequately, they tend to like their physician and see him or her as a good doctor," she says.

Taking the time to build a rapport with a patient translates into direct advantage for the physician, adds Smith. According to recent studies, patients who like their physician are less likely to sue even in the event of an adverse outcome. "The extra five minutes you spend effectively communicating with the patient could save a law suit," says Smith.

As part of building rapport, it is important that patients have access to their physicians, say Smith. MSMS has received complaints from patients who claim that office staff refuse to allow them to speak with the physician. If a patient feels he or she is being prevented from speaking to the physician they can allege abandonment, Smith explains. Physicians should set limits on the gatekeeping capacity of the receptionist.

"Many problems with patients could be averted, says Smith, "if the office staff or physicians take the time to effectively communicate and establish a good rapport with the patients."



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-James S. Todd, MD



AMA Executive Vice President

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colleagues, your family and your friends. The materials listed below come from the AMA and MSMS. They will be supplemented as the reform debate continues. As the AMA's Doctor Todd says:

"Physicians are the key to any success in health system reform. What we have to do as a profession is fuel and shape the national debate. Health system reform is not a spectator sport. Every one of us has to be involved."

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| "How Will Clinton Health Reform Proposal Affect You and Your Family?" Four-page bro- chures for office and clinic analyze Clinton plan based upon 10 basic questions public  |      | Five PO/PHO organizational experts one-hour videotape of presentations at MSMS/MPMLC PO/PHO Conference September 10-11 in Southfield. \$75  | \$       |
| should raise about proposed reforms. AMA and MSMS seals imprinted. \$1 for packs of 25, minimum order five packs   |      | Package of three videotapes above from MSMS/MPMLC Southfield Conference on POs/PHOs. \$225  Information on new managed care programs  | \$_      |
| "The Role of the Physician in Health Care" 32-page special issue of Business and Health magazine positioning physician as key player in health care delivery. For office and clinic display. MSMS and AMA seals imprinted. \$1 each, minimum orders of 100 |      | being developed by Michigan third party payors.  Free  Compendium of MSMS and AMA policies regarding health system reform.  \$5 per copy  | 6        |
| Copies of AMA and MSMS analyses of plans proposed by Clinton Administration, U.S. Republican and Democratic parties and state legislators.  Free   | \$   | "A Review of Health Status in Michigan."  Comprehensive document with executive summary, describing role of Michigan citizens' poor health status on rising health care costs.  Free  TOTAL Charge \$ | <b>D</b> |

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# **NEW MEMBERS**

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

| Mohammed Asgar, MD<br>24950 Lincoln Ct #179<br>Farmington Hls, MI 48335           | Р     |
|---|-------|
| Allan F. Avbel, MD<br>Mescosta General Hosp.<br>Big Rapids, MI 49307              | R/END |
| <b>Jay E. Berkelhamer, MD</b><br>2799 W. Grand Blvd/Ped<br>Detroit, MI 48202-2689 | PD    |
| <b>Ricardo G. Cacdac, MD</b><br>150 S. Johnson<br>Pontiac, MI 48341               | GS    |
| Stephanie Chun, MD<br>1000 N. Telegraph<br>Dearborn, MI 48128                     | OBG   |
| Charles G. Colombo, MD<br>44199 Dequindre #409<br>Troy, MI 48098                  | OPH   |
| Michael J. DeBacker, MD<br>6533 E. Jefferson #326<br>Detroit, MI 48207            | · FP  |
|   |       |

| Jasubhai K. Desai, MD<br>1675 Kingsway Ct.<br>Trenton, MI 48183               | IM/GE     | Usman G. Master, MD<br>23077 Greenfield Ste 156<br>Southfield, MI 48075      | NEP/IM |
|---|-----------|--|--------|
| Michael A. Dorman, MD<br>6330 Orchard Lake Rd #120<br>W. Bloomfield, MI 48322 | D/IM      | <b>Kevin Neff, MD</b><br>580 Forest Ave #8<br>Plymouth, MI 48170             | AN     |
| Anna Fraymovich, MD<br>11900 E. 12 Mile Rd<br>Warren, MI 48093                | PD        | Vali Orandi, MD<br>14555 Levan #310<br>Livonia, MI 48154                     | R      |
| <b>Nirlu Gil, MD</b><br>19356 W. Harbour Village<br>Northville, MI 48167      | Р         | Elizabeth Raphael, MD<br>405 Leroy<br>Ferndale, MI 48220                     | EM     |
| Effie Moten Gumbs, MD<br>16604 Edinborough<br>Detroit, MI 48219               | Р         | Ulrich O. Ringwald, MD<br>811 Oakwood Ct.<br>Rochester, MI 48307             | A/IM   |
| C. Nolen Hudson, MD<br>1001 Mulholland<br>Bay City, MI 48708                  | GS        | Claudia Schroeder, MD<br>4353 N. US 31<br>Scottville, MI 49454               | GP     |
| Ishmael Jaiyesimi, DO<br>2875 Troy Ctr Dr #2020<br>Troy, MI 48084             | ON/HEM/IM | Rod S. Silverman, MD<br>406 S. 7th Street<br>Ann Arbor, MI 48103             | AN     |
| <b>Abida A. Khan, MD</b><br>1803 Rapids Way<br>Rochester Hills, MI 48309      | Р         | Steven E. Stein, MD<br>1579 W. Big Beaver #B-8<br>Troy, MI 48084             | PS/GS  |
| <b>Urmilla Khilanani, MD</b><br>44199 Dequindre #65<br>Troy, MI 48098         | IM        | Donald H. Stewart, MD<br>3535 W. 13 Mile Rd #555<br>Royal Oak, MI 48073      | OPH    |
| Achin Kim, MD<br>455 S. Livernois<br>Rochester Hills, MI 48307                | A/PD      | Gregory G. Stevens, MD<br>543 N. Main Ste 221<br>Rochester, MI 48307         | IM     |
| Swarn Mahajan, MD<br>26601 Berg Rd. #235<br>Southfield, MI 48034              | Р         | <b>Danny F. Watson, MD</b><br>3150 Telegraph #205<br>Bingham Farms, MI 48025 | P/N    |
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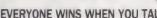


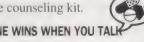


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# **MEETINGS**

#### **MSMS Meetings**

#### November

**9-11,** MSMS Annual Scientific Meeting, Westin Hotel, Detroit, MI. Contact: Sarah Cressman, MSMS Assistant for Physician Education, (517) 336-5727.

**16, 17,** MSMS/MPMLC Fundamentals of Risk Management. November 16, Fetzer Center, Kalamazoo, MI. November 17, Port Huron Hospital, Port Huron, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

**18-19,** MSMS Orientation to the Medical Office. Treasure Island, Saginaw, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

**24,** MSMS Pain and Symptom Management for the Incurably III: Alternatives to Assisted Suicide, Fetzer Center, Kalamazoo, MI. Contact: Tracy Baker, MSMS Communications, (517) 336-5786.

**30,** MSMS/BCBSM Medicare Update. Holiday Inn, Flint, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

#### December

**1, 2,** MSMS/BCBSM Medicare Update. December 1, Best Western Domino Farms, Ann Arbor, MI. December 2, WMU Regional Center, Grand Rapids, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

**2-3,** MSMS Medical Biller Training Series (Other Carriers). Novi Hilton, Novi, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

#### **AMA Meetings**

#### November

**20,** Physicians' Forum: Agenda for Action, Dallas, TX. Call 800-621-8335 for details and registration information.

#### December

**5-8,** AMA Interim Meeting, New Orleans, LA. Contact: Judy Marr, Manager, MSMS Department of Communications and Professional Relations, 517-336-5744.

#### **Other Meetings**

#### December

**4,** Washington School of Medicine: Current Management of Hepatic and Biliary Disease, Ritz Carlton Hotel, St. Louis, Missouri. Contact: Continuing Medical Education, Washington University School of Medicine, (314) 362-6893.

**9-11,** Pet and Spect Imaging in Oncology, Thomas B. Turner Building, John Hopkins Medical Institutions, Baltimore, Maryland. Contact: Patty Campbell, (410) 955-6046.



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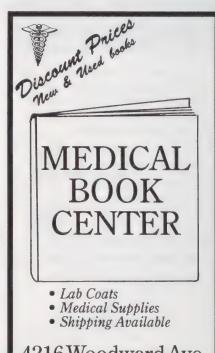
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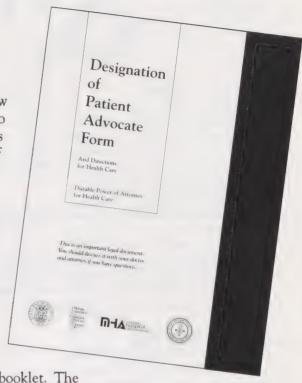
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#### MICHIGAN STATE MEDICAL SOCIETY



# Seminars Conferences

for November and December 1993

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#### Pain and Symptom Management for the Incurably Ill: Alternatives to Assisted Suicide

November 24 Fetzer Center, Kalamazoo
This afternoon program is recommended for all health care
professionals concerned with managing chronic pain among their
patients. \$55 for MSMS members or non-members. For more
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336-5770.

#### Orientation to the Medical Office

November 18-19 Treasure Island, Saginaw

This one and a half day program is designed to provide the new employee with an overall understanding of the medical office to ensure patient satisfaction, improve office efficiency, and reduce medical liability. \$95 per person for MSMS/MMGMA/MSMA members or office staff, \$125 for non-members.

#### **Medical Biller Training Series**

Medicaid

November 4-5 Novi Hilton, Novi

Commercial Carriers/Managed Care

December 2-3 Novi Hilton, Novi

special accommodations.

These small-group training sessions are designed for the biller needing to know more about specific carriers. They will address rules and procedures to maximize reimbursement for the carrier, as well as the relevant procedure and diagnostic coding information. \$300 for MSMS/other Members, \$400 for non-members.

#### MSMS/BCBSM Medicare Update

November 30 Holiday Inn, Flint

December 1 Holiday Inn North Plaza, Ann Arbor December 2 WMU Regional Center, Grand Rapids

These seminars have been developed to help physicians and their medical office staff keep current on the latest Medicare changes. \$85 MSMS members or their office staff, \$115 for non-members.

#### MSMS/MPMLC Risk Management Clinical Conferences

#### Colon and Prostate Cancer: Avoiding Two Common Malpractice Traps

November 3 WMU Regional Center, Grand Rapids

November 4 Novi Hilton, Novi

This full-day seminar will address the methods for diagnosing and managing these conditions and the common misadventures in related malpractice cases. \$157 for MSMS members, \$185 non-members.

#### **Fundamentals of Risk Management**

November 16 Fetzer Center, Kalamazoo November 17 Port Huron Hospital

These afternoon programs will address the importance of communication between physicians and patients and their families, as well as the importance of medical record documentation. \$65 for MSMS members, \$80 non-members.

If you or other staff in your office would like a detailed brochure on these and upcoming MSMS programs, please call the Office of Physician Education at (517) 336-5784.

120 W. Saginaw St.

East Lansing, MI 48823

Michigan Medicine

| Please type or print c   | ar mailing list to receive   | On Card<br>Seminar Title:                 | Locat                                     | ion     |                                   | Date  | Fee  |
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A confirmation will be sent to you.

# **CATEGORY I COURSES**

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

#### November

**8,** MSMS Forum on Family Violence. Location: Wayne County Medical Society, Detroit, Michigan. Sponsor: Michigan State Medical Society. Contact: Office of Physician Education, (517) 336-5784. Approved for: 7 hours Category I Credit.

**10-11, Potpourri #3. Location:** Ashman Court Hotel, Midland, Michi-

gan. **Sponsor:** The National Procedures Institute. **Contact:** Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. **Approved for:** 15 hours Category I Credit.

19-20, Sclerotherapy/Peripheral Vascular Evaluation. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 11.5 hours of Category I Credit.

**19-20,** Advances in Psychiatry V **1993.** Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Psychiatry. **Contact:** Melody Curry, Registrar, Towsley Center for Continuing Medical Education, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 14 hours Category I Credit.

23-28, Pediatric Board Review. Lo-

cation: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Michigan Association of Pediatric Program Directors, Michigan Chapter, American Academy of Pediatrics. Contact: Marie McKnight, Registrar, Towsley Center for Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 936-9800. Approved for: 60 hours Category I Credit.

**24,** Effective Compassion for the Incurably III: Alternatives to Assisted Suicide. Location: Fetzer Center, Kalamazoo, Michigan. Sponsor: Michigan State Medical Society. Contact: Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48826-0950, (517) 336-5784. **Approved for:** 3.5 hours Category I Credit.

#### December

**3-4,** 2nd Annual Women's Health Care for the Primary Care Provider.

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#### **CATEGORY I COURSES**

Continued from page 55

Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Department of Family Practice and Department of Obstetrics and Gynecology. Contact: Melody Curry, Registrar, Towsley Center for Continuing Medical Education, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. Approved for: 14 hours Category I Credit.

#### **January**

**21-22,** EGD (Gastroscopy). Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 12 hours Category I Credit.

**24-26,** Fiberoptics Workshops for the Difficult Airway. Location: Disney's Yacht Club Resort, Lake Buena Vista, Florida. **Sponsor:** University of Michigan Medical School, Department of Anesthesiology. **Contact:** Melody Curry, Registrar, Towsley Center for Continuing Medical Education, P.O. Box

1157, Ann Arbor, MI 48106-1157. Approved for: 16 hours Category I Credit.

**27-28,** Colposcopy for the Primary Care Physician. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 12.25 hours of Category I Credit.

**29,** LEEP/LETZLOOP. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 6.25 hours of Category I Credit.

#### **February**

**2,** The International College of Surgeons - Michigan Division, Annual Scientific Session. Location: Sinai Hospital, Detroit, Michigan. Sponsor: International College of Surgeons, Michigan Division. Contact: Sheri Waldman, 313-493-5279. Approved for: 6 hours Category I Credit.

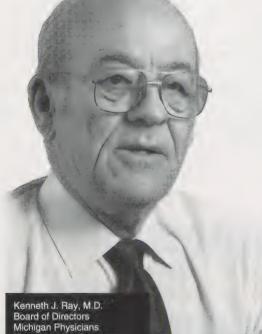
**4-5,** Sclerotherapy. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 11.25 hours of Category I Credit.

11-12, Stress EKG. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallman, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 12 hours of Category I Credit.

**25-26,** Colonoscopy/Common Anorectal Disorders/Hemorrhoid Treatment. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 12.25 hours of Category I Credit.

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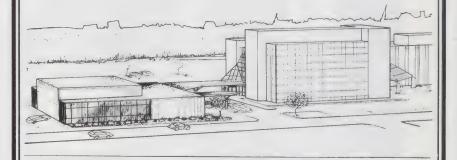




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HEALTHSPAN - a regional health care system with sites in Minneapolis, Saint Paul and leading communities within a 150 mile radius of the Twin Cities, offers practice opportunities in: EMERGENCY MEDICINE, FAMILY PRACTICE, HEMATOLOGY/ONCOLOGY, INTERNAL MEDICINE, OBSTETRICS/GYNECOLOGY, PEDIATRICS, PHYSIATRY, PSYCHIATRY AND URGENT CARE. Contact: HealthSpan, Medical Affairs, 2810 57th Avenue North, Minneapolis, MN 55430. (800) 248-4921 or (612) 574-7756.

DAVIS-SMITH IS WORKING WITH A NUMBER OF CLIENTS THROUGHOUT MICHIGAN. Some of the opportunities available for board eligible/board certified physicians: PEDIATRICS - join a thriving private practice of two pediatricians. Call would be 1:6,

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Continued on page 61

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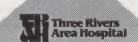
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Oakwood Health Services, located in southeast Michigan, is recruiting qualified BC/BE physicians to affiliate with its hospital network, which includes:

1,100 physicians representing most every medical and surgical subspecialty
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Oakwood Hospital, Oakwood Health Services' largest facility, offers extensive educational and training programs, including accredited residency programs in Obstetrics and Gynecology, Family Practice, Internal Medicine, Radiology, and a Transitional Program.

#### **Ob/Gyn Faculty**

Excellent opportunity for a clinically oriented general Ob/Gyn to join the faculty of the 16 position, Ob/Gyn Residency program at Oakwood. The program is supported by three subspecialties.

Faculty positions available are:

- · Director of Gynecology
- Director of Research
- · Director of Ambulatory Care

#### Pediatrics

Expanding private practice and hospital based/faculty career opportunities are available throughout southeast Michigan.

These positions offer:

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- Pediatric residency education component
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#### **Orthopedic Private Practice**

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|-----------------------------|-----|
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# PRESIDENT'S PAGE

# Graduate Medical Education Let's Keep Up!

By Gilbert B. Bluhm, MD

ne the major missions of the Michigan State Medical Society is to promote the scientific knowledge of physicians. Not only does MSMS have the legal responsibility to monitor physician education programs, but it also has the charge to advocate physician skill and ethics of practice for quality patient care. The AMA and MSMS, along with its county medical

societies, specialty societies and hospital medical staffs, provide meaningful educational experiences for Michigan physicians. Evidence of these activities is present in the Michigan State Medical Society's Annual Scientific Meeting this month.

This annual event always contains major current topics from diverse areas of medical advancement. The best teachers from both academic and private arenas participate together to provide the most recent advances in scientific knowledge for patient care application.

Physicians certainly realize that in order to provide quality care they must

be dedicated to being perpetual students throughout all of their professional lives. Nevertheless, it calls to mind that certain changes in state licensing laws which



While the legacy of excellent medical education for physicians in the US has been well established, "revolutionary" changes are now on the horizon for both graduate and post-graduate medical training...

Vigilance must be our watchword as Congress considers laws which may dictate and regulate our medical schools to the detriment of our profession and the ultimate health of the citizens.

occurred in the 1970s stimulate physicians to maintain up-to-date clinical information.

Many hospitals, our three medical schools and other medical organizations are accredited locally to provide quality continuing medical education. Many programs throughout the year are outstanding, but quality and diversity of specialty and primary care practice interests for

physicians provided by the MSMS *three-day* Annual Scientific Meeting which occurs in November each year can rarely be excelled.

While the legacy of excellent medical education for physicians in the US has been well established, "revolutionary" changes are now on the horizon for both graduate and post-graduate medical training. The health system reform proposed currently by the Clinton Administration clamors for more primary care physicians. Those so considered are physicians who are actually specialty trained as family practice, general internal medicine, and general pediatrics. Vigilance must be our watchword as Congress considers laws which may dic-

tate and regulate our medical schools to the detriment of our profession and the ultimate health of the citizens.

Let's keep up!

Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. Clin Cardiol. 1991;14:146-151.

#### PRAVACHOL® (Pravastatin Sodium Tablets)

CONTRAINDICATIONS

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the catient apprised of the potential hazards to the fetus. patient apprised of the potential hazard to the fetus.

Ever Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in

rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin.

Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of monitored at more therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinua-

then therapy should be discontinued. Persistence of significant aminotransierase elevations rollowing discontinua-tion of therapy may warrant consideration of liver biopsy. Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been re-ported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weak-ness in conjunction with increases in creatine prosphokinase (CPR) values to greater than 10 times the upper limit

pravastaint interest patients give a Divention Line of the Complexity defined as inside attention of more in the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopath should be considered in any patient with diffuse myagiags, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gernflorozii, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with rocyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and genificrozi showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving lacebo, genifibrozii, or pravastatin monotherapy. Myopathy was not reported in this trial (see PECALTIONS: Drug Interactions). One patient developed myopathy wen clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. The use of fibrates alone may occasionally be associated with myopathy. The combined use continued. The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS).

This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin. Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency: A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3a-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and affil-life (ttV2) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or unexplained. Applications of the patients of the patien

weakness, particularly if accompanied by malaise or fever.

Drug interactions: immunosuppressive Drugs, Gernfibrozil, Niacin (Nicotinic Acid), Erythromycin: See WARN-INGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

chrome P45U system will occur.

Cholestyramine/Colestipion: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of prawastatin. However, when prawastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before codestipol and a standard meal, there was no clinically significant decrease in beloavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfam: In a study involving 10 healthy male subjects given prawastatin and warfarin concomitantly for 6 days bioavailability parameters at steady state for prawastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but after the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothorombin time after days of concomitant therapy). However, bleeding and extreme protongation of prothorombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothorombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed. 
Cimetidine: The AUC\_p\_thr for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered. 
Gernifibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gerniforzoil: in a AUC, Cmax, and Timax for the pravastatin metabolite SQ 31,906. Combination in the pravastatin and gerniforzoil is generally not recommended. In interaction studies with aspirin, antacids [1 hour prior to PRAWACHOL (pravastatin sodium)], cimetidine, nicotinic acid, or probucol, no statistically significant differences in bioavailability were seen when PRAWACHOL was administered.

Other Drugs: During clinical trials, no noticeable drue interactions were reported when PRAWACHOL was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers,

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced (p<0.004) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituliary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA neductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vescular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower

infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose

infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion statring at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomate males at the highest dose (p<0.01). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls (p<0.05). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in means serum drug levels approximately 3, 15, and 33 times hi

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Pregnancy: Pregnancy Category A: See Cont HAINDLCHICNS.
Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter²). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAMACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAWACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: General.) ADVERSE REACTIONS

AOVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were saymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients. Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below, also shown are the exceptances of natients in whom these medical events were helieved to be related or nossibly related to the day.

percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

| Body System/Event   | All Events %             |                      | Events Attributed to Study Drug % |                      |
|---------------------|--------------------------|----------------------|-----------------------------------|----------------------|
|                     | Pravastatin<br>(N = 900) | Placebo<br>(N = 411) | Pravastatin<br>(N = 900)          | Placebo<br>(N = 411) |
| Cardiovascular      |                          |                      |                                   |                      |
| Cardiac Chest Pain  | 4.0                      | 3.4                  | 0.1                               | 0.0                  |
| Dermatologic        |                          |                      |                                   |                      |
| Rash                | 4.0°                     | 1.1                  | 1.3                               | 0.9                  |
| Gastrointestinal    |                          |                      |                                   |                      |
| Nausea/Vomiting     | 7.3                      | 7.1                  | 2.9                               | 3.4                  |
| Diarrhea            | 6.2                      | 5.6                  | 2.0                               | 1.9                  |
| Abdominal Pain      | 5.4                      | 6.9                  | 2.0                               | 3.9                  |
| Constipation        | 4.0                      | 7.1                  | 2.4                               | 5.1                  |
| Flatulence          | 3.3                      | 3.6                  | 2.7                               | 3.4                  |
| Heartburn           | 2.9                      | 1.9                  | 2.0                               | 0.7                  |
| General             |                          |                      |                                   |                      |
| Fatigue             | 3.8                      | 3.4                  | 1.9                               | 1.0                  |
| Chest Pain          | 3.7                      | 1.9                  | 0.3                               | 0.2                  |
| Influenza           | 2.4°                     | 0.7                  | 0.0                               | 0.0                  |
| Musculoskeletal     |                          |                      |                                   |                      |
| Localized Pain      | 10.0                     | 9.0                  | 1.4                               | 1.5                  |
| Myalgia             | 2.7                      | 1.0                  | 0.6                               | 0.0                  |
| Nervous System      |                          |                      |                                   |                      |
| Headache            | 6.2                      | 3.9                  | 1.7"                              | 0.2                  |
| Dizziness           | 3.3                      | 3.2                  | 1.0                               | 0.5                  |
| Renal/Genitourinary |                          |                      |                                   |                      |
| Urinary Abnormality | 2.4                      | 2.9                  | 0.7                               | 1.2                  |
| Respiratory         |                          |                      |                                   |                      |
| Common Cold         | 7.0                      | 6.3                  | 0.0                               | 0.0                  |
| Rhinitis            | 4.0                      | 4.1                  | 0.1                               | 0.0                  |
| Cough               | 2.6                      | 1.7                  | 0.1                               | 0.0                  |

Statistically significantly different from placebo

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis, fremory, etrigo, memory loss, paresthesia, peripheral neuropathy, peripheral perupathy, perupa

liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma, anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been

Laboratory less Anormainties: increases in serum transaminase (ALI, ASI) values and DPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophila has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, collestipol, nicotinic acid, probucol and gemifibrozii. Preliminary data suggest that the addition of either probucol or gemifibrozii to therapy with lovastatin or pravastatin is not associated with greater reduction in LDL-cholester than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to been presented. Microathy and chapter productions without without. those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrazii, erythromycin, or ligid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: Skeletal Muscle and PRECAUTIONS: Drug Interactions.)

e been no reports of overdoses with pravastating

Issued: March 1993

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.



TI: MICHIGAN MUDICINE

# MEDICINE

DECEMBER 1993 VOL. 92, NO. 12

Award-Winning Journal of the Michigan State Medical Society

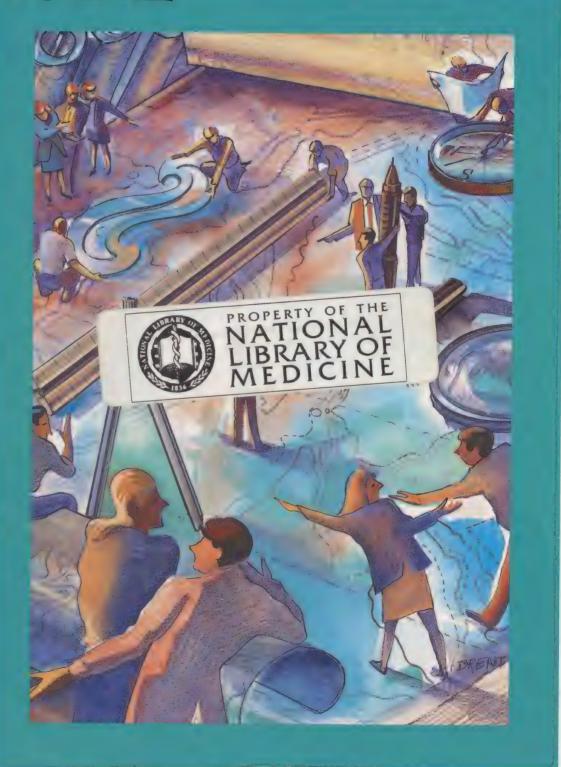


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## MICHIGAN MEDICINE

DECEMBER 1993 VOLUME 92, NO. 12 Award-Winning Journal of the Michigan State Medical Society





# **Charting Our Course for Health System Reform:**

# Together We Can Achieve Our Goals

Universal coverage. Health alliances. National Health Board. Liability reform. Antitrust relief. Global budgets. Freedom of choice. Quality of care. These are just some of the many issues which are now being discussed as we begin our journey toward health system reform.

Michigan physicians should rest assured that their medical society is working hard to educate physicians, patients and legislators about physicians' concerns. MSMS, along with the AMA, believes unequivocally that any health system reform passed by Congress must put patients first, and must protect the physician-patient relationship.

Over the past several months, MSMS has developed programs, services and informational campaigns – all designed to help physicians prepare themselves for the changes which lie ahead.

This issue of *Michigan Medicine* outlines the many programs and services MSMS has developed and is now offering to its members. What follows is a practical guide to health system reform in Michigan. This issue serves as the first of many which will be devoted to health system reform issues.

#### INSIDE THIS ISSUE:

- 6 Introduction
  BY GILBERT B. BLUHM, MD
- 8 Text of MSMS Speech/Slide Show on Clinton Plan
- 17 Executive Summary of AMA/MSMS
  Positions on Health System Reform
- 19 Executive Summary of MSMS Health Status Report
- 23 Glossary of Terms
- 27 More on POs and PHOs: Your Key to Autonomy and Control

BY WILLIAM E. MADIGAN

29 POs and PHOs: A Paradigm Shift for Physicians

BY WILLIAM J. CARBONE

33 Guide to Federal Legislators

35 MSMS/AMA Offer Tools for Educating Patients

#### **DEPARTMENTS**

- 37 SOUNDOFF!
- 41 LEGAL BRIEFS
- **45 REIMBURSEMENT ROUNDUP**
- **46 NEW MEMBERS**
- 53 MEETINGS
- 55 CATEGORY I COURSES
- 57 CLASSIFIEDS
- **63 ADVERTISING INDEX**
- **64 PRESIDENT'S PAGE**

#### In next month's issue:

1994 MSMS Membership Directory

Cover Illustration: Robert L. Brent

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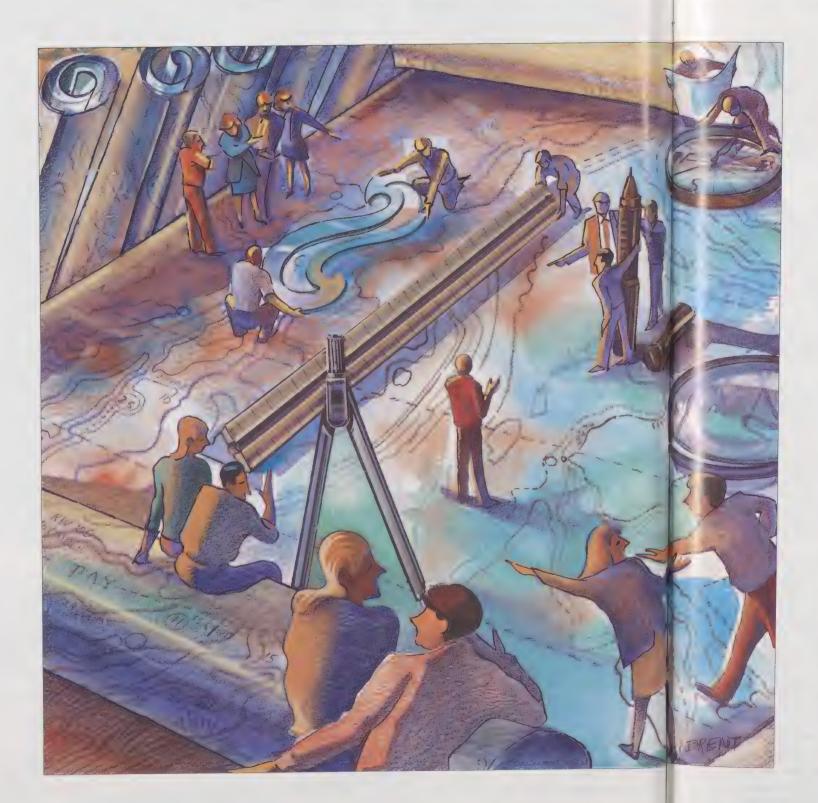




## **Charting our Course for Health System Reform:**

Working together we can achieve our goals

By Gilbert B. Bluhm, MD. MSMS President



niversal coverage. Health alliances. Health plans. National Health Board. Liability reform. Antitrust relief. Global budgets. Freedom of choice. Quality of care. These are just some of the many issues which are now being discussed as we begin our journey toward health system reform.

Michigan physicians should rest assured that their state medical society is working hard to educate physicians, patients and legislators about our concerns. MSMS, along with the AMA, believes unequivocally that any health system reform passed by Congress must put patients first, and must protect the physician-patient relationship.

Over the past several months, MSMS has developed programs, services and informational campaigns -- all designed to help physicians prepare themselves for the changes which lie ahead.

One of the informational tools recently developed by MSMS is a 40minute speech and slide presentation which outlines the major components of the American Health Security Act, unveiled by President Clinton in September. Also included is an outline of several state initiatives and special services being developed to aid physicians in moving to integrated health systems. Rounding out the speech is a description of the MSMS Communications Plan for educating physicians about proposed changes and their impact. This issue of Michigan Medicine is one step in the MSMS plan.

Following are highlights of the speech. I encourage you to study the information carefully. Should you wish to present the speech and slide show to your colleagues, or have someone from MSMS do it, please contact Mary Anne Ford or Judy Marr at MSMS. THE STATE OF

December 1993



# Members may use this text of MSMS speech, system slide show on Clinton plan

#### Universal Coverage

ince the AMA plan for health system reform-Health Access America-was released in 1990, a primary goal of organized medicine has been to assure that all Americans can obtain affordable health care coverage. President Clinton has incorpo-

> rated several AMA recommendations pertaining to universal coverage into his health system

reform proposal.

#### Here's more information about the speech and slide show-and how to get it

MSMS has developed a 40minute speech and slide presentation on health system reform as a tool for doctors in speaking to county medical societies, hospital medical staffs and other professional groups. Handouts like a glossarv of health system reform terms and details on the Clinton plan and other Congressional proposals also are provided with the presentation.

Several MSMS leaders already have used the speech and slides. They are President Gilbert B. Bluhm, MD, speaking to the Michigan State Chamber Foundation: President Elect Jack L. Barry, MD, speaking to the Bay County Medical Society: Board member Willard S. Stawski, MD. speaking to the Michigan Medical Group Managers Association: Board member B. David Wilson, MD, speaking to South Haven Hospital and Physician Organizations Committee Chair Fred E. Patterson, MD, conducting a course at the 1993 MSMS Annual Scientific Meeting.

To order copies of the presentation, call Mary Anne Ford at (517) 336-5721 or Judy Marr at (517) 336-5744.

Under President Clinton's proposal, 37 million Americans who are now uninsured would be covered. Insurers would not be able to exclude coverage for preexisting conditions and coverage would continue for those changing jobs. Medicaid would be rolled into the private sector, eliminating some of the payment differences that now restrict Medicaid patients' access to needed health care services.

Like the AMA. President Clinton recommends expanding access to health insurance coverage by building on the existing employer based health insurance system.

Some of the President's proposals for making insurance more affordable involve caps on premiums and spending limits. MSMS has many concerns about those limits, which will be addressed later in this presenta-

President Clinton recommends that all citizens and legal residents be enrolled in a health insurance plan, that could be purchased through state or regional health alliances.

Every citizen would have a health security card that would guarantee access to a defined set of benefits.

The benefit package includes coverage for comprehensive medical and hospital services

and specified clinical preventive services. More details about the benefit package will be released as legislation is developed and considered. The AMA is concerned that the preventive benefit package is inadequate but believes that the other benefits are generally consistent with AMA recommendations.

Under the President's proposal, the benefit package would be updated by a national health board.

#### Health Alliances

Health Alliances-formed at the state and regional level-are the centerpiece of President Clinton's managed competition reform proposal.

Every state would have at least one health alliance, but there may be several regional alliances in each state. Health alliances are essentially purchasing cooperatives, acting as conduits between health plans and individual or group purchasers. Health alliances must contract with any health plan that meets prescribed standards.

Under the President's proposal, all coverage would be purchased through an alliance, except for employers with more than 5,000 employees. These employers may form their own corporate alliance and contract directly with plans.

State and regional health alliances would have a tremendous amount of purchasing power, which the AMA believes will actually thwart competition. To promote true competition, the AMA supports the formation of corporate alliances by any employer with more than 500 employees.

Health alliances would be required to have provider advisory boards and publish information for consumers. This includes specific information about each plan with which the alliance contracts. Data on plan cost, access restrictions and quality would be collected and disseminated, along with information on physicians, hospitals and others participating in the plans.

Each alliance would offer several plan options, with different levels of cost sharing. The options include a completely capitated plan, with low cost sharing for consumers; a PPO or point of service option with high cost sharing and financial disincentives to receive care from a physician or other professional who is outside of a network; and a feefor-service plan. Corporate alliances also are required to offer a fee-for-service plan.

The AMA has long advocated health system re-

form that offers individual consumers choices of delivery systems and payment options. Although President Clinton's proposal includes several options, the proposed structure favors capitated plans.

Each alliance would be required to offer one feefor-service plan option and may limit fee-for-service plans to three. Fee-for-service plans would be chosen by alliances based on competitive bidding. Payment would be based on a fee schedule that is negotiated between physicians and other providers and the alliance. Under the fee-for-service option, balance billing would be prohibited.

#### Health Plans

Health plans provide coverage for the nationally guaranteed benefit package through contracts with state or regional alliances.

Health plans may be operated by an insurance company, a health maintenance organization or by physicians and hospitals. The efforts of MSMS to encourage development of physician organizations and physician-hospital organizations will help physicians in this new competitive environment.

President Clinton recommends that physicians be allowed to participate with more than one plan. This is an important protection that we will pursue in any reform proposal.

Health plans must accept all eligible individuals and comply with insurance market reforms recommended by President Clinton.

Provider advisory boards-elected by the providerswould be required, along with grievance procedures and appeals mechanisms for consumers.

Health plans would be required to collect and provide information to the state or regional health alliances. This would include information on costs; on the qualifications of participating providers, availability of providers, utilization review programs; and rights and responsibilities of both the plans and consumers. The information provided by the plans would ultimately be shared-through the health alliance-with consumers and with state and national oversight boards.

#### National Health Board

The President's proposal creates an independent national health board responsible for setting national standards and overseeing the establishment and administration of the new health system by states.

The board would establish requirements for state

plans and monitor compliance with those requirements. It would interpret and update the nationally guaranteed benefit package, establish and enforce implementation of the national budget for health care, and establish and manage a performance-based quality management and improvement system.

The seven-member board would be appointed by

the President with the advice and consent of the Senate. At least one member would represent the interests of states. Board members would serve as employees of the federal government and could not hold any other employment.

The AMA opposes centralized decision-making and arbitrary spending limits as being unworkable. This proposal creates a new federal bureaucracy with price control authority that can set goals without taking into account changes in disease, demographics or demand. It is unacceptable that no place has been reserved on this board for a physician or AMA representative.

#### Quality Management Program

Under the President's plan, a new bureaucracy would be created to implement customer-focused continuous quality improvement.

An advisory council under the National Health Board would oversee the quality management program. The council would consist of 15 members representing consumers, purchasers, health plans, experts in public health and quality of care, and states.

The council would develop a core set of quality and performance measures and consumer survey questions and update them as needed. It also would conduct consumer surveys to measure access to care, use of health services, outcomes and satisfaction. Alliances would collect information on individual health plans and compare them. The council would set a national program to develop practice guidelines, scientific standards, and priorities.

Continued on following page

#### Doctors lead health system reform debate

Ninety-one percent of respondents to a recent public opinion survey said they'd trust written information about the effects of the Clinton health system reform proposal if that information came from their family physicians. The poll, commissioned by the Michigan Hospital Association, asked respondents whether they would trust or distrust various groups to provide that information. Hospitals ranked second behind physicians with a 79 percent trust response, and employers ranked third with 71 percent.

Strong public trust in doctors, coupled with their unique role in health care, underscores the important fact that doctors must lead in shaping reforms.

Continued from page 9

The AMA is concerned that physicians have not been included specifically in the advisory council. The AMA recommends a comprehensive program that would recognize the profession's well-established accrediting and quality assurance programs.

#### Administrative Simplifications

One important element of health system reform must be the elimination of costly and wasteful regulation and paperwork.

#### MSMS president participates in White House briefing

MSMS President Gilbert B. Bluhm, MD, participated last month in a White House briefing on President Clinton's proposed Health Security Act and a discussion of organized medicine's priorities in health system reform. That briefing was conducted by President Clinton's senior health policy advisor Ira Magaziner. Representatives from national specialty and state medical societies around the country attended.

Under President Clinton's proposal, a uniform, simplified claim form must be implemented by January 1995, along with national standards for coding, automated transactions and electronic data interchange. The National Health Security Card would provide access to patient data.

These are all welcome changes which, if implemented properly and in a reasonable timeframe, would allow physicians and others to devote less time to paperwork and more time to patient care. The AMA will focus its efforts to assuring that these efforts to create new, streamlined information systems do not result in micromanagement or create new administrative burdens.

Another administrative improvement suggested by the Administration is the creation of a single unique

provider identification number. Again, the AMA will work to assure that this effort to streamline information systems does not result in creation of new administrative burdens.

Several Medicare and CLIA regulations are specifically addressed in the reform proposal.

Some Medicare changes are: integration of claims processing for Medicare Parts A and B; elimination of pre-procedure approval for 10 procedures; limits on system changes and a shift in review focus from individual cases to patterns.

Some recommended changes to the Clinical Laboratory Improvement Act regulations include a higher threshold for inspections; the addition of more tests to the waiver category; and a shift in inspection focus from all laboratories to only high risk laboratories.

Although the AMA continues to advocate repeal of

CLIA, these recommendations are consistent with those suggested by the AMA.

#### Liability Reform

Liability reform encompasses changes in tort law and the development of alternative approaches to resolving patients' claims against physicians and other providers.

The Clinton plan proposes that each health plan establish an alternative dispute resolution system based on models developed by the National Health Board. Consumers would have to submit their complaints through the alternative system first, but could pursue a complaint in court if unsatisfied with the outcome. The AMA believes that alternative dispute resolution programs should be a function of an impartial state authority, rather than health plans themselves.

The plan would require a certificate of merit affidavit signed by a specialist practicing in a field relevant to the claimed injury.

The plan also proposes to limit attorneys' fees to  $33\ 1/3$  percent unless a lower state limit exists. This has virtually no impact since this is the typical share of awards that attorneys take from clients now.

The Department of Health and Human Services would set rules for public access to information in the National Practitioner Data Bank and would authorize demonstration projects for enterprise liability. The AMA objects to both of these proposals. The plan does not address limits on noneconomic damages such as those which currently exist in Michigan, a deficiency in addressing the high cost of excessive litigation and awards.

#### Primary Care/Workforce

The Clinton plan addresses the need to adjust the distribution of the health care workforce, with an emphasis on primary care training.

The President recommends that 50 percent of physicians in training must be in primary care after five years. This would be done through a phase-in period, which would require primary care slots to increase seven percent each year and specialty slots to decrease 10 percent each year.

The Department of Health and Human Services would allocate positions based on the recommendations of a new National Council on Graduate Medical Education. The national council would allocate slots to regional councils, who would then distribute

positions to individual programs. However, this would have ultimate veto power.

The allocations would be based on program quality, relevance of training programs to actual practice, minority representation, and participation of locally coordinated plans. Any program exceeding its slot assignment would receive no national funding, so institutions that seek independent funding of positions would be punished.

The AMA opposes these arbitrary quotas. Quotas do not address many reasons physicians choose a specialty, such as lifestyle choices, practice environment, educational background, levels of educational debt, and individual interest. The AMA also is concerned that federalized central decision-making will not guarantee an adequate supply of primary care physicians. Allocating slots and funds to individual programs also will result in a fragmented system.

Primary care incentives would include loan forgiveness for primary care practice, primary care retraining programs, emphasis on minorities and community training at the undergraduate level, doubling the training positions for nurse practitioners, physician assistants, nurse midwives, and special emphasis for mental health and substance abuse prevention, geriatrics, school-based health care, community care and managed care. The Medicare 10 percent bonus for nonprimary care in urban shortage areas would be eliminated and the bonus for primary care in all shortage areas would be doubled to 20 percent.

#### **Antitrust Relief**

In his preliminary proposal, President Clinton's plan posed several changes in the antitrust laws.

Small hospitals would be allowed to merge and the Department of Justice and Federal Trade Commission would have to publish guidelines providing antitrust safety zones for hospital mergers and joint ventures and for some physician network joint ventures. Physician joint ventures would have to have less than 20 percent market share and share financial risk. Within the safety zones, physicians would be allowed to bargain collectively with health plans about payment, coverage, medical care decisions and other matters.

During the transition to the new system, physicians would be allowed to negotiate with health plans and to form their own plans within a narrow safe harbor. The safe harbor would protect physicians and other providers from the market power of third party

payers that are forming health plans, and would allow them to establish and negotiate prices as long as the physicians share financial risk that goes beyond fee discounting. The safe harbor would *not* apply to the implicit or explicit threat of a boycott.

The AMA feels that these provisions are insufficient in letting physicians compete in a system that will be dominated by large corporate managed care entities. Provisions must be included that allow physicians to collectively negotiate with these large entities, as well as for the AMA and other societies to negotiate on behalf of physicians.

#### Spending Limits/Global Budgets

Although the plan is organized around competition, consumer choice, and negotiating power, a national health budget is proposed to hold health care inflation to that of other sectors of the economy in the future.

The plan describes a national health care budget triggered by changes in premium as a targeted backstop to market action. The target increase in premiums for 1996 is the consumer price index plus 1.5 percent, CPI plus one percent for 1997 and CPI plus 0.5 percent for 1998. In 1999 and beyond, the increase would be the CPI unadjusted.

Continued on following page



Several Michigan physicians meet with key legislators

More than two dozen Michigan physicians and other health care leaders met in Southfield with Michigan Congressman Sander Levin (D-Southfield)(above, far left) and West Virginia Senator Jay Rockefeller (standing at center) last month to talk about health system reform issues. Both legislators serve on the House Ways and Means Committee. That committee will be one of nine in the House reviewing health system reform proposals before the Congress, including President Clinton's plan. Michigan Congressman David Camp (R-Midland) also sits on that committee. MSMS President Gilbert B. Bluhm, MD, (above holding microphone) was among the physicians who attended the meeting.

Continued from page 11

The national per capita based premium would be set by the national board, along with a system to adjust the premium at the alliance level for risk factors like age and gender.

The AMA staunchly opposes the setting of any national budget. Decision-making in health care based on economics is not in the best interests of patients. It will lead to rationing that cannot address the difficulties and inequities in our current health care system. The AMA believes that a participatory process that includes physicians might be useful to establish true goals that are flexible and based on

patient needs, rather than imposing stringent and arbitrary caps on spending.

#### MSMS leaders discuss reform issues with newspaper editors

To keep health system reform continuously in the public eye, MSMS leaders are visiting newspaper editors statewide to discuss health system reform. MSMS President Gilbert B. Bluhm, MD. recently talked with Detroit Free Press Editor Joe Stroud in the editor's downtown office. Doctor Bluhm stressed the positives of the Clinton proposal-universal access, a package of benefits for all and employer-based coverage-and pointed out the weaknesses-loss of physician choice, underfunding and possible rationing of health care services.

#### Financing

The plan also outlines payment for health coverage. It is unclear how the government responsibilities in the plan would be financed, but Medicare savings and so-called "sin" taxes have been discussed.

Payment for health coverage would be divided into two shares: contributions by individuals and families and contributions by employers. Alliances would offer consumers a choice of health plans. All consumers would receive the same schedule of premiums for enrollment, based on family type.

Employer contributions would pay for 80 percent of the average priced plan in the alliance for each family type. Families and individuals would pay the difference between employer contribution and the actual cost of the plan they selected.

Families and individuals with incomes below 150 percent of poverty in a regional alliance would be allowed to apply to their alliance for help in paying their premium. The subsidy would depend on family income and the average premium for that family type in the alliance. Subsidy costs would be borne by the federal government.

Working individuals and families would be permitted to pay their share of premiums through withholdings from wages, withholdings from

sources of non-wage income, or direct payments to the alliance.

For each of their eligible full-time employees, employers participating in a regional alliance would contribute 80 percent of the appropriate per worker contribution. Subsidies would cap total premium contributions for employees at 3.5 percent to 7.9 percent of the firm's payroll, depending on the size of the employer. Employers would be permitted to pay part or all of the employees' share of the premium, but they would be required to make the same dollar contribution for all employees with the same family status, unless a collective bargaining agreement required otherwise.

#### State Responsibilities

States would assume primary responsibility for ensuring that all eligible individuals have access to a health plan that delivers the national benefit package. Each state would be required to designate an agency to coordinate state responsibilities.

States would be responsible for administering subsidies, certifying health plans that would participate in a region, ensure the availability of a plan priced at or below the weighted average premium, submit to the National Health Board plans to regulate health plans, and administer data collection and quality management and improvement.

States also would provide for governance of alliances, including methods for selecting boards of directors and advisory boards. Each state would be required to establish one or more regional alliances to cover every resident in the state by January 1, 1997. States would be allowed to establish a single payer system rather than an alliance system offering multiple plans, or to establish a single payer alliance for a portion of the state.

The AMA strongly opposes the establishment of a single payer health care system. The national plan rejected a single payer system for good reason. Allowing a state to subject its residents to such an unreasonable approach would be contradictory and make little sense.

#### State Initiatives

Even before the President's plan was unveiled in September, state proposals have been discussed and introduced in Michigan.

In May, Representative Bennane introduced a managed competition style bill entitled the "Michigan

Health Access Plan." This bill is currently pending in the House Public Health Committee. Also in May, Representative David Hollister introduced a single payer bill entitled "Michicare." This bill also is pending in the House Public Health Committee.

MSMS does not anticipate these democratically introduced bills passing the House of Representatives or the Senate.

On the Republican side of the aisle, Representative John Jamian has formed a task force to study the current health care system, find its weaknesses and enhance the value of the system as it functions today. This task force is expected to release its report in January 1994.

Governor Engler has created a special office on health care reform to begin reviewing the entire system and all of the plans surfacing to reform it. At this time, the office is meeting with agency directors and has no specific plans to develop a Michigan system reform package.

#### Other Federal Bills

Although President Clinton's plan has captured most of the attention at the national level, there are several other proposals that have been introduced in Congress.

The Conservative Democratic Forum proposal or the Cooper proposal is most closely aligned with the Clinton plan; however, major differences exist. For example, the Cooper proposal does not require all US citizens to enroll in a health plan. Instead, all citizens would be *eligible* to enroll in a health insurance plan purchased through state or regional health purchasing cooperatives.

All small employers-less than 501 employeeswould have an agreement with the purchasing cooperative in the area to cover employees.

Differing from the Clinton plan, the Cooper proposal also would:

- Repeal Medicaid;
- Require uniform cost-sharing in all health plans;
- Impose no global budget or price control mechanisms;
- Provide no relief from clinical laboratory regulations

This proposal had 87 co-sponsors in the House of Representatives as of September.

The Chafee or Senate Republican Health Care Task Force Bill, like the Clinton plan, would require all US citizens to obtain health insurance. However,

no employer mandate would be established. Employers would receive favorable tax treatment if they provided federally certified health plans to their employees. Like the Clinton plan, Medicaid and Medicare would both be maintained.

The Chafee bill does not impose price controls or a global budget for the private sector. Per capita spending limits would be applied to Medicaid and Medicare based on historical costs.

The House Republican Leader's Task Force on Health has developed a plan which would require employers to offer, but not pay for health insurance. This would be achieved through a series of small market insurance reforms and tax changes to provide fairness and allow employers to group together to purchase insurance. Employees also would be encouraged to establish medical savings accounts linked to catastrophic health insurance policies.

The House Republican Plan would grant states the flexibility to reform Medicaid, including the use of mandatory managed care programs. No cost sharing or national health board are established in this proposal.

The House Republican Plan does not impose a global budget. It is the only plan on the table which does not utilize health alliances or purchasing cooperatives.

This plan had 115 co-sponsors in the House of Representatives as of September.

## MSMS initiatives to assist physicians in integration

In response to ongoing changes in the health care market in Michigan and in anticipation of federal reform that emphasizes managed care organizations and regional integration, MSMS has developed services to help physicians make the transition to an integrated system.

In order to assist physicians in establishing physician organizations (POs) and physician-hospital organizations (PHOs), MSMS has created a new division called Physician Organization and Management Services (MSMS/POMS). Through POMS, physicians can utilize the services of 'physician friendly' consultants to help them through the many issues in organizing and operating POs and PHOs. POMS services are provided on a fee-for-service basis at extremely reasonable prices.

Through POMS, physicians can obtain the major

Continued on following page

Continued from page 13

services needed to create a PO or PHO, including:

- environmental analysis
- organizational analysis
- strategic/business planning legal
- management information systems

Interested physicians should contact Tom Plasman or Tom Wolff at MSMS for additional information.

#### MSMS keeps state legislators informed on physician activities

This month MSMS is in the midst of a six-part mailing to state legislators to update them on what Michigan physicians are doing to spur debate on health system reform. The mailings began immediately after President Clinton's Sept. 22 announcement of his reform plan. So far, lawmakers have received a comparison of President Clinton's proposal to the AMA's Health Access America plan and an executive summary of an MSMS compendium of all standing MSMS and AMA policies on health system reform. They've also received MSMS/ AMA "Think About It!" bookmarks offering 10 basic questions the public should raise about proposed reforms. See page 35 of this Michigan Medicine to order. MSMS will continue mailing current information on its health system reform activities to state lawmakers.

## Communication with physicians

MSMS and AMA have developed extensive communications plans to keep physicians, patients, the media and legislators informed about the health system reform process.

In the area of communications with physicians, MSMS already has published a special report in the September 28 *Medigram* and will provide continual updates in this weekly newsletter. This month's cover story kicks off the first in a series of special reports on health system reform in *Michigan Medicine*.

Through its fax network, MSMS will continue to quickly share information on health system reform with state specialty society, county and alliance leaders. Information for county and specialty society bulletins is available.

A compilation of MSMS and AMA policies on health system reform and related issues is available to assist members in

responding to questions about organized medicine's priorities. (See page 17 for executive summary.)

MSMS also put itself ahead of the reform process by sponsoring a major conference on the development of POs and PHOs. A "Masters Series" on health system reform will provide more information on organizing, and on managed care, antitrust and negotiation, data and credentialing. (See page 26 for program details.)

#### Communication with patients

Communication with patients is important because patients should be informed about the plan and its consequences.

MSMS and AMA activities to keep patients informed include development of the "Think About It!" bookmarks listing the top 10 questions people should ask about health system reform. To help focus discussion on important public health issues associated with health care costs, MSMS has done a synopsis of studies revealing the health status of Michigan citizens, which when compared nationally, is not too good. (See page 19 for executive summary.)

The AMA now is offering physicians a poster to place in their offices with the 10 questions on reform and the AMA answers to them. AMA also has a brochure with 20 questions and answers that physicians may purchase to give to patients. Every three weeks from now through next summer you will be seeing paid AMA advertising in national magazines with the headline "The Moment of Truth." The ad copy will be updated as the reform debate progresses.

#### Communication with Media

Both MSMS and the AMA will be working with the media, answering specific questions from reporters and issuing news releases as needed.

MSMS and AMA leaders already are visiting with editors of major newspapers. We will promote our "health status" report to media, indicating that personal responsibility is necessary to control health care costs. MSMS and AMA will write letters-to-theeditor and ask individual physicians to do the same through the MSMS Physician Communication Network. We already are participating in radio and TV talks shows to get our ideas heard and to answer the public's questions.

#### Communication with Legislators

Because the national plan has many repercussions at the state level, and because state proposals will continue to be discussed, communication with legislators will be a key component in health system reform.

To keep in touch with legislators, MSMS will continue to testify on the various health reform bills outlined earlier. We will send copies of pertinent information to state legislators. The Physician Legislative Network will be asked frequently to contact

their legislators and an all out effort will be made to increase the membership of the Michigan Doctors Political Action Committee (MDPAC).

The AMA, of course, will be engaging in similar activities with Congress.

#### Conclusion

It is clear from the broad scope of the President's plan that there is much detail to be discussed, digested and debated. The AMA has pledged to work constructively with the President and Congress to develop a system designed to meet the best interests of patients and health care professionals, and President and Mrs. Clinton have indicated that the plan is open for debate. Both MSMS and the

AMA believe that any health system reform passed by Congress must put patients first, and protect the physician-patient relationship. MSMS is working hard at the state level to build this awareness among Michigan physicians, citizens and legislators.

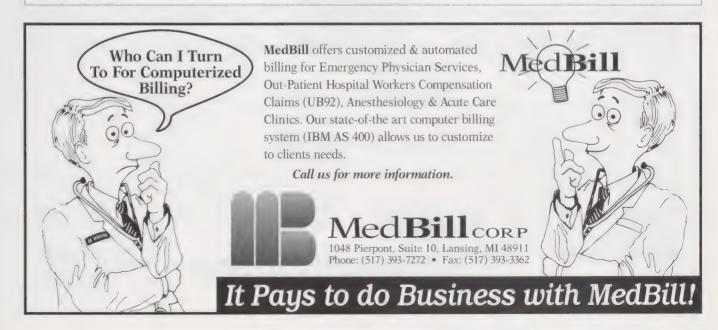
MSMS also is working with the AMA to strengthen this awareness in Michigan's congressional delegation in Washington, DC. We also will continue to update our information and resources to help you participate in this important debate. Talk with your patients about health system reform and its implications. Take advantage of opportunities to meet with civic and community groups to share our concerns. Become an active participant in legislative and communications networks. Together, we can achieve successful reform of our health system.

#### **AMA/MSMS** tools on health system reform available

MSMS also has created other tools to help physicians educate themselves, their patients and others on health system reform. These include "Think About It!" posters offering the 10 basic questions the public should raise about proposed reforms, information on new managed care programs and videotaped presentations on forming physician organizations and physician hospital organizations.

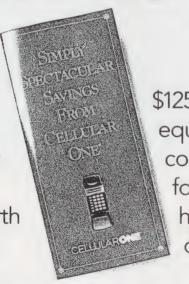
MSMS already has distributed many of these tools to physicians. To date, materials sent out include more than 46,000 "Think About It!" bookmarks; 1,500 "Think About It!" posters; 1,500 executive summaries of the MSMS/AMA standing health system reform policy compendium; and 1,500 copies of the MSMS report, "A Review of Health Status in Michigan."

See page 35 of this *Michigan Medicine* if you'd like to order these or any other health system reform tools available from MSMS.



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When you sign a one-year service contract on certain rate plans before December 31st, we'll give you this valuable book with coupons worth over \$1000. It includes up to



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# MSMS creates compendium of AMA/MSMS positions on health system reform

o help physicians prepare for health system reform discussions in any context, i.e. with other doctors, with lawmakers, with the media and with patients, MSMS has created a compendium of all standing MSMS/AMA positions on health system reform. Following is an executive summary of that compendium. Physicians can order a complete copy by turning to page 35 of this Michigan Medicine.

Allied Health Professionals - The AMA and MSMS support the establishment of written protocols between physicians and nurse practitioners for the delivery of health care services, and opposes the delivery of medical services by independent nurse practitioners. The AMA and MSMS believe that reimbursement systems should pay physicians or their institutions directly for the services of allied health personnel, and such personnel should be under the supervision of practicing physicians.

Any Willing Provider - At this time, MSMS has not taken a position on this issue, but has discussed the possibility of seeking an amendent to this bill which would forbid the practice of selective contracting with physicians.

**Arbitration** - MSMS believes all alternative health care delivery system contracts should include arbitration agreements in which the patient agrees to arbitrate any dispute arising from care delivered under the terms of the contract.

**Basic Benefits** - The AMA and MSMS support an affordable basic benefits package for all Americans, either through their employer, a government program, or a risk pool.

**Billing Reform -** The AMA and MSMS support eliminating balance billing for patients who have incomes below 200 percent of the poverty level.

Cost Containment - Quality of Health Care - The AMA and MSMS are committed to bringing health care costs under control and support an enhanced insurance and health care market as the best way to achieve cost control while maintaining high quality health care and patient choice of treatment and physician.

Credentialing, Data Collection, and Profiling - The AMA and MSMS (1) protests economic credentialing by third

party payors in which economic factors are placed above quality of care; (2) will educate the public and physicians about economic credentialing practices and medicine's responses; and (3) will investigate the feasability and desirability of utilizing quantitative outcomes data and/or other quality of care measures in lieu of economic credentialing for participation in managed care networks and insurance plans.

**Development of Practice Parameters -** The AMA and MSMS are working diligently to facilitate the development of practice parameters and urge quality assurance programs and utilization review systems to adopt parameters developed by professional organizations.

**Drug Utilization Review -** The AMA and MSMS support drug utilization review (DUR) that focuses on quality of care. The cost of drugs should be considered only after clinical and patient considerations are addressed.

**Durable Power of Attorney -** MSMS supports Public Act 312 that allows patients to appoint an advocate to make medical care and treatment decisions when they are not capable of doing so themselves. MSMS supports living will legislation, which would allow persons to express their views in writing regarding withholding or withdrawal of medical treatment in the event that they are unable to participate in medical treatment decisions and are either terminally ill or permanently unconscious.

Elimination of Anti-Trust - The AMA and MSMS strongly support changes in anti-trust laws to allow physicians and physician organizations to engage in group negotiations with collective purchasers, managed care plans, insurers, and other payors, on issues of clinical autonomy, quality, payment, and cost.

**ERISA** - The AMA and MSMS support modifications to the federal Employee Retirement and Income Security Act to ensure that any rules and negotiation requirements apply equally to self-insured and insured health benefit plans. This would help re-establish the true insurance principle of spreading risk among the broadest possible population.

**Fee Disclosure** - The AMA and MSMS support physicians discussing with patients their charges prior to treatment. The AMA and MSMS also support insurers disclosing their reimbursement amount prior to treatment to improve cost consciousness.

Continued on following page

Continued from page 17

Freedom of Choice - The AMA and MSMS support freedom of choice for both the patient and the physician. All Americans should have unrestricted freedom to choose the physician of their choice, the place of treatment of their choice, and the payment mechanism of their choice. Physicians should retain the freedom to choose their method of earning a living (fee-for-service, salary, etc.), and the right to charge their patients their usual fee that is fair, regardless of coverage arrangements between the patient and the insurers.

**Global Budgets** - The AMA and MSMS strongly oppose global budgets because they are arbitrary, incomplete, have unpredictable consequences, ration health care services, address only the symptoms and not the causes of health care cost, and will lead to a substantial increase in the regulatory and administrative burdens placed on health care delivery.

**Insurance Reform** - The AMA and MSMS support implementing community rating, eliminating preexisting conditions, establishing "reinsurance" pools, and requiring three different options for insurance coverage: a benefit payment schedule, UCR, or prepaid.

**Managed Care** - The AMA and MSMS support effective managed care techniques that are fair and equitable to physicians in ensuring that high quality health care services are delivered to patients. The AMA and MSMS also support disclosure of utilization control mechanisms and policies to enrollees prior to enrollment.

Managed Competition - The AMA and MSMS's view of managed competition depends upon how the concept is implemented. The AMA and MSMS support free-market competition among all competitors on a level playing field, as a result, would strongly oppose any system that gave managed competition a competitive advantage through governmental policies.

**Mandated Employer Insurance** - The AMA and MSMS support an employer mandate which would require employers to insure their employees and their dependents, which would be possible by reforming and enhancing the insurance and health care market.

Medicaid Reform - The AMA and MSMS believe that federal and state governments must ensure access to and funding for medical care for persons below the poverty level. Medicaid must be expanded so that all persons below poverty can receive a uniform set of health benefits.

**Medical Education and Primary Care** - The AMA and MSMS support adequate funding for graduate medical education and medical school loan repayment programs for physicians willing to serve in underserved areas. The AMA has broad, general support for primary care. At this time,

MSMS has no position on the issue of reducing the numbers of non-primary care physicians.

**Medical Technology -** The AMA is aggressively working to assure that medical technologies are used appropriately. The AMA principles for technology assessment call for development of complete, accurate information for physicians on safety, effectiveness, and clinical indications with major involvement of the medical profession and with input from both the private and public sectors. The AMA supports reevaluation of technology on a continuing basis and elimination of obsolete technologies.

**Outcomes Research** - It is the policy of the AMA to continue to promote outcomes research as an effective mechanism to improve the quality of medical care.

"Play or Pay" - The AMA and MSMS reject the "play-or-pay" approach, which gives employers the option of providing coverage to their workers or paying into a public program. By giving employers this option, "pay-or-play" threatens private/public financing mechanisms and will eventually lead to a single payor, government-run, national health insurance system.

**Provider Tax** - At this time, MSMS has no standing position on the issue of imposing a tax exclusively on physicians or other health care providers including a license fee, an assessment, a levy or an occupational tax.

**Rationing** - It is the policy of the AMA to study projections of future health care costs and assist society in prioritizing services, and study ways in which the American public can be educated on the implications of health care rationing.

**Rural Health Care -** The AMA and MSMS support and encourage the development of health care education, primary care, and assorted programs to blossom health care services in rural, underserved areas.

**Self Referral**-The AMA and MSMS oppose when physicians refer patients to facilities in which they have an ownership interest, due to a potential conflict of interests, unless there is a demonstrated need in the community for the facility and alternative financing is not available.

**Single Payor** - The AMA and MSMS reject the "single payor approach" as a way to achieve universal coverage. Under such a system, medical decisionmaking would be dominated by budgetary considerations, not by what is best for patients.

Universal Coverage - All Americans should have defined insurance coverage. The AMA and MSMS believe that universal coverage is best achieved through a combination of employer-required insurance, Medicaid and Medicare reform, and other specific initiatives that build upon the strengths of our current health care system.

# MSMS "Review of the Health Status of Michigan's Citizens" expands debate on costs

tate and federal discussions of health system reform have created an unprecedented interest in the issue of health care costs. Issues of cost and benefit coverage also have been raised through UAW negotiations with the auto companies. MSMS also participates in discussions with third party payers about which benefits will be reimbursed and has repeatedly supported better coverage of preventive care.

Up to this point, much of the discussion of health care costs has focused disproportionately on payments to physicians and hospitals, administrative waste, and the cost of prescription drugs. Although this list is an integral part of the discussion, it is not comprehensive.

Michigan has proven to be one of the worst states in chronic disease incidence and among the worst in lifestyle and health behavior factors. Attention has been focused on the increased "medicalization" of social problems, such as violence and poverty. Discussion of these issues and how they affect the cost and quality of health care in Michigan must occur with the public, with payers, and with elected officials if the dialogue on controlling health care costs is to be productive.

"A Review of the Health Status of Michigan's Citizens" expands the focus of the debate into these other important areas that influence health status. It is intended as a resource document to be used with a wide variety of audiences, such as the media, other provider groups, elected representatives at the local, state and federal level, the general public, and patients.

Following is the executive summary of this study.

#### Chronic Disease

Chronic disease is an ailment that is permanent, leaves a residual disability or requires rehabilitation or long periods of care. Michigan ranked first in deaths for nine chronic diseases in 1986. Michigan's combined mortality rate for these nine chronic diseases was 483 deaths per 100,000 population. The lowest mortality rate for the United States was 427 per 100,000. Michigan also compared unfavorably in the prevalence of risk factors associated with these diseases, such as smoking, obesity, and drinking.

#### Cancer

Over 500,000 people in the U.S. will die of cancer in 1993. Cancer was the second leading cause of death in Michigan as well. Michigan had a higher death rate than the U.S. between 1985 and 1989, at a rate of 177 deaths per 100,000 population. States surrounding Michigan also have higher mortality rates than the U.S. average: Illinois at 179, Indiana at 179, and Ohio at 181. The National Cancer Institute estimated overall costs for cancer in 1990 at \$104 billion: \$35 billion for direct medical costs, \$12 billion for lost productivity and \$57 billion for mortality costs. Cancer accounts for 10 percent of the total cost of disease in the U.S. Estimated new cancer cases for Michigan in 1993 is 42,000.

#### Cardiovascular Disease

Heart disease is the number one killer in America, and Michigan's death rate ranks a dismal 43rd in the country, higher than all of its closest neighbors. The American Heart Association estimated that heart disease cost the U.S. \$108.9 billion in 1993. Diseases falling under the category of CVD are coronary heart disease, angina pectoris, stroke, hypertension, rheumatic heart disease, congenital heart defects and atherosclerosis. Michigan has the third highest rate of deaths from coronary heart disease at 125.6 per 100,000 population. Stroke is the third leading cause of death in both Michigan and the U.S., ranking behind heart attack and all forms of cancer.

#### Diabetes Mellitus

Michigan ranks second in self reported diabetes mellitus prevalence at 7.1 percent of the population, 2.1 percentage

Continued on following page

Continued from page 19

points above the median for the United States. People with diabetes mellitus are at an increased risk for lower-extremity amputations, cardiovascular disease, diabetic eye disease and end stage renal disease. For 1987, the annual health care costs (direct costs from medical care and lost productivity) associated with diabetes were an estimated \$20.4 billion. With the increasing occurrence of the disease due to population growth and the aging of the population, the economic burden of diabetes will rise.

#### Lifestyle Choices

It is said today that we are spending four cents of every human services dollar on prevention and 96 cents on cure, a decrease from five cents in 1980. This trend is not irreversible. With the upswing of health promotion and the high cost of health care, some are trying to modify their behavior by quitting smoking, losing weight and exercising. It is very important to recognize the impact lifestyle choices have on health and the cost of insurance and care.

**Tobacco use** is the most important single preventable cause of death in the United States. It is a major risk factor for diseases of the heart and blood vessels; chronic bronchitis and emphysema; cancers of the lung, larynx, pharynx, oral cavity, esophagus, pancreas, and bladder; and other problems such as respiratory infections and stomach ulcers. Smoking-related health care costs \$22 billion annually; 75 percent of these costs are incurred by those under the age of 65. One in five deaths in the United States in 1988 was caused by cigarettes. Michigan has the seventh highest smoking rate with 29.2 percent of the population smoking.

Obesity and sedentary lifestyle can seriously affect health and longevity, according to the National Institutes of Health Consensus Development Conference on weight loss and control. It is associated with elevated serum cholesterol, hypertension, and noninsulin-dependent diabetes mellitus. Excessive weight also increases the risk for gallbladder disease, gout, coronary heart disease and some types of cancer and has been implicated in the development of osteoarthritis of the weight-bearing joints. Approximately 34 million adults in the United States are overweight (20 percent above desirable weight), 13 million of whom are severely overweight (40 percent above desirable weight). In order to reduce this risk factor both exercise and diet are important.

#### Substance Abuse

In 1988, the total cost of substance abuse reached \$144 billion, an increase of 25 percent over a three-year period. Substance abuse is now recognized as a disease of addiction

requiring professional help and counseling for recovery. The cost to society of not putting more effort into both prevention and cure include the cost of treating other illnesses brought on by the disease, decreased productivity, and disruption of families.

Alcohol dependency and abuse is a major public health problem in the United States. The cost of alcohol abuse was \$85.8 billion in 1988, an increase of 22 percent over three years. Alcohol is a factor in approximately half of all homicides, suicides, and motor vehicle deaths. Michigan has a higher frequency of at-risk drinking behavior than the U.S. in heavy drinking, binge drinking, and drinking and driving.

In addition to the health care, rehabilitation and productivity costs of alcoholism, **drug abuse** has the additional costs of crime enforcement. The cost of drug abuse was \$5.83 billion in 1988, an increase of 32 percent since 1985. In 1988, 21 million Americans used cocaine at least once and 21 million also had used marijuana in the last year. One in four adolescents is at very high risk of alcohol and other drug problems, even after excluding high risk youth that have dropped out of school. The Michigan Department of Public Health reported that 27 percent of people with AIDS and 35 percent of people with HIV contracted it through intravenous drug use.

#### Disease Incidence

AIDS and HIV infection have become the most discussed and debated new challenge to the health care system, a good deal of the time overshadowing other public health problems, such as sexually transmitted diseases, the resurgence of tuberculosis cases, and the immunization problem now faced by the United States. Public health in America is faced with new and more difficult challenges, even after many infectious diseases were dramatically reduced in what many consider the most significant public health achievement in the past 100 years.

AIDS is the number one medical problem in the United States, according to public opinion. AIDS is the fastest growing cause of early life loss, accounting for 644,245 years of potential life lost in 1991. The projected 1995 cost of medical care for those with HIV and AIDS will be \$15.2 billion. The lifetime costs of treating someone with AIDS are estimated to be \$102,000, based on an average 20-month survival from diagnosis to death. Michigan follows the national pattern of increasing cases and deaths by year of diagnosis. As of July 1993, 4,729 cases were diagnosed and 2,533 people had died from AIDS in Michigan. Michigan ranks fifteenth in the country at a rate of 66 cases reported per 100,000 population.

After many decades of steady decline, the incidence of **tuberculosis** (TB) is increasing in the United States. The Centers for Disease Control has estimated that from 1985

through 1991 over 39,000 excess cases of TB have accumulated. Accompanying this increase has been the appearance of a new strain, MDR-TB, that is resistant to the primary drugs used. Since 1985, the TB rate in Michigan has remained steady, but Detroit saw a marked increase from 1985 to 1992. TB rates are higher in urban areas, among the elderly, the poor, people with weakened immune systems due to illness or exhaustion, and substance abusers.

Almost 12 million cases of **sexually transmitted diseases** occur annually, 86 percent of them in persons aged 15 to 29 years. By age 21, approximately one in every five young people has required treatment for an STD. Although AIDS has received much attention lately, there are many other STDs that pose serious health risks. Included in the category of STDs are syphilis, gonorrhea, herpes simplex virus, hepatitis B, human papilloma virus, and chlamydia. Chlamydia is now the most prevalent STD in the United States, with an estimated three to four million new cases occurring among adults and infants each year.

Immunizations have played a major role in the success of the public health system at reducing many infectious diseases. Nonetheless, there are still many members of our society (the very young, the elderly, and members of minority groups) that remain at increased risk of vaccine-preventable diseases. The Centers for Disease Control estimate that only half of inner-city two-year-olds are immunized; nationally the rate is 70 percent. The impact of declining vaccination rates is already being felt. Measles outbreaks are now rather regular after reaching an all-time low in 1983, and rubella and whooping cough are now at the highest number since 1982.

#### Children's Health

Michigan ranks in the bottom half on many categories measuring the health of children. The Michigan Medicaid program is more inclusive than that of many other states, thereby improving the state's ranking on access to prenatal care and number of uninsured children. However, in many other categories used to measure children's health (infant mortality, low birth weight, reported child abuse), Michigan falls short.

#### Violence

The incidence of violence and abusive behaviors, including domestic violence, has been increasingly recognized as an important public health problem because of its growing prominence as a source of health problems and health care expenditures experienced by Americans. Injuries resulting from violence exact a heavy economic toll, both in direct medical costs and in foregone job productivity. Hospitals

also encounter difficulties because many victims of violence who are admitted are uninsured and, in some locations, account for a significant portion of uncompensated care. These crime victims often require specialized, technology-intensive care. From domestic violence to drive-by shootings, these acts are straining the medical system, not to mention the damage done to families, children, and the way people behave.

#### Poverty

Nearly one of every eight Americans live in a family with an income below the federal poverty level. Health disparities between poor people and those with higher incomes are almost universal for all dimensions of health. Poverty increases the chances of infant death, chronic disease, and traumatic death. Poverty also is often associated with significant developmental limitation—growth retardation affects 16 percent of low income children younger than age 6.

#### Unintentional Injuries

Unintentional injuries are the fourth leading cause of death in the United States, killing about 100,000 people a year, and are a major cause of disability. Motor vehicle crashes account for approximately one-half of these deaths. Injuries have been estimated to cost the United States more than \$100 billion annually due to lost productivity and medical care. From 1987 to 1990, 21,861 Michigan residents died of injuries. Injuries are the leading cause of death for residents age eight months to 44 years. Transportation accidents accounted for 7,270 deaths in Michigan between 1987 and 1990.

#### **Environmental Health and Pollution**

Uncertainties exist about the toxic and ecologic effects of many synthetic chemicals and fuels in modern society. An estimated 82 percent of major industrial chemicals have not been tested for their toxic properties and links to specific diseases. Only a small proportion of chemicals have been adequately tested for their ability to cause or promote cancer.

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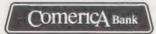
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## Health System Reform Glossary of Terms

Administrative Costs - Costs related to utilization review, insurance marketing, medical underwriting, agents' commissions, premium collection, claims processing, insurer profit, quality assurance activities, medical libraries and risk management. The AMA supports eliminating administrative expenses that do not add value to health care dollars.

**Balance Bill** - The fee amount remaining after patient copayment and insurer payments. The AMA supports eliminating balance billing for patients who have incomes below 200 percent of the poverty level.

**Basic Benefits Package**-A core set of health benefits that everyone in the country should have - either through their employer, a government program, or a risk pool. The AMA supports an affordable basic benefits package for all Americans.

**Charity Care** - Free or reduced fee care provided due to financial situation of patients. In 1989, physicians provided an estimated \$6.8 billion in services as charity care. The AMA encourages charity care by physicians.

**Community Rating** - Premiums based on the potential health risks or claims experience of the entire population in an area. The AMA supports community rating as necessary to achieve fairness and affordability of health insurance. The AMA opposes experience rating which bases premiums on the claims made by an employer's group.

Cost Containment-Approaches to limit growth in health spending and the amount of health spending. AMA-supported approaches include eliminating un-necessary care, targeting optimum health treatments, lowering administrative costs, enacting professional liability reforms, and enhancing the health care and insurance marketplaces. AMA opposes spending caps such as global budgets.

**Defensive Medicine** - Physician practices just to reduce risk of a liability claim, e.g., performing diagnostic tests of marginal value. Defensive medicine totaled an estimated \$20.7 billion is 1989. The AMA supports liability reforms to reduce the need to practice defensive medicine.

ERISA-The Employee Retirement Income Security Act. ERISA exempts self-insured health plans from state laws governing health insurance, including contribution to risk pools, prohibitions against disease discrimination, and other state health reforms. The AMA supports amending

ERISA to level the playing field between self-insured plans and other types of insurance plans.

Federal Deficit - Federal government spending in excess of revenues. Interest on money borrowed by the federal government was the third largest budget item in 1990, behind defense and Social Security. Spending to pay interest on the nation's debt increases 13 percent annually, a rate of increase higher than for health care, defense, or Social Security. The deficit threatens the viability of any health plan administered by the federal government.

**Fee Disclosure** - To improve cost consciousness, the AMA supports physicians discussing with patients their charges prior to treatment. The AMA also supports insurers disclosing their reimbursement amount prior to treatment.

**Global Budgets** - Limits on categories of health spending. The AMA opposes global budgets as arbitrary limits that reduce access while ignoring underlying systemic problems.

**GNP** - Gross National Product. The dollar value of all goods and service produced by a country. In 1990, U.S. health spending was 12 percent of GNP.

**Health IRAs** - Proposed tax-deferred plans to encourage saving for future medical expenses. Funds in health IRAs could be later cashed out for medical expenses. The AMA supports health IRAs.

Infant Mortality Rate - Deaths in the first year of life per 1,000 births. U.S. rate in 1990 was 9.1, 19th among developed countries. According to the U.S. General Accounting Office, 50 percent of these deaths are due to lifestyle factors, 20 percent due to environmental factors, 20 percent due to biological factors, and 10 percent due to inadequate health care.

**Job Lock** - The inability of individuals to change jobs because they would lose crucial health benefits. The AMA supports insurance reforms, such as eliminating preexisting condition limitations, to assure portability of coverage.

Managed Care - Systems and techniques used by third party payors to control utilization of health services. Includes review of medical necessity, incentives to use specific providers, and case management. The AMA supports disclosure of utilization control mechanisms and policies to enrollees prior to enrollment.

Continued on following page

Continued from page 23

Managed Competition - A health insurance system that would band together employers, labor groups, and others into insurance purchasing groups. Employers and other collective purchasers would make a set contribution toward purchase of insurance for individuals they represent. The set contribution acts as an incentive for insurers and providers to compete. The AMA supports enhanced market competition in a pluralistic health system but opposes plans that unfairly concentrate market power of payors or are given a competitive advantage through government policies.

**Mandated Employer Insurance** - Employers are required to provide health benefit coverage for their employees. The AMA supports mandated employer insurance for basic health benefits.

**Medicaid** - A state/federal health benefit program for the poor who are aged, blind, disabled, or members of families with dependent children. Each state sets its own eligibility standards. Only 40 percent of individuals with income below the poverty level currently are covered. The AMA supports Medicaid coverage for every one below poverty level.

**Medical Technology** - Includes drugs, devices, techniques, and procedures used in delivering medical care and the support systems for that care. There are no accurate estimates of how much new technologies contribute to health spending.

**Medicare** - The federal health benefit program for the elderly and disabled that covers over 34 million Americans or 16 percent of the population at an estimated annual cost of over \$133 billion. Medicare pays for 26 percent of all hospital care and 23 percent of all physician services.

**National Health Expenditures** - Total spending on health services, prescription and over-the-counter drugs and products, nursing home care, insurance costs, public health spending, and health research and construction. In 1992, U.S. health expenditures are estimated at over \$800 billion.

National Health Insurance - The government as the single payor of medical bills. Key features often include: federal financing from general tax revenues; beneficiary contributions and/or payroll taxes; government fee controls; and prospective budgets. The AMA opposes national health insurance because it would have a negative effect on patient choice of treatment, quality of care, and medical innovation.

**Per Capita Health Care Spending**-Annual spending on health care per person, Per capita spending in 1992 is estimated at \$3.057.

**Physician Income** - Net income after expenses and before taxes. Median net income for physicians in 1990 was \$130,000. Physician net income in 1990 was 13 percent of U.S. health expenditures.

**Physician Services** - One portion of national health care expenditures. Includes physicians' overhead, administrative expenses, and income. Total expenditures for physician services in 1990 were \$125.7 billion or 18.9 percent of total health spending.

**Play or Pay** - Employers would be required to provide health insurance to their employees or to pay a special government program tax. The AMA opposes play or pay because employers would increasingly opt to "pay" into the government program, leading to national health insurance.

**Portability** - An individual changing jobs would be guaranteed coverage with the new employer, without a waiting period or having to meet additional deductible requirements. The AMA supports insurance reforms to make insurance coverage portable.

**Practice Parameters** - Strategies for patient management, developed to assist physicians in clinical decision making. Parameters improve quality and assure appropriate utilization of health services. The AMA supports developing practice parameters to help assure patients optimum care and wiser spending of health dollars.

**Preexisting Condition Limitations** - A provision in insurance policies that excludes health conditions existing prior to coverage sign up. These limitations exclude specified conditions entirely or for a specified period. When an individual changes jobs and enrolls in a new insurance plan, these limitations can cause a critical gap in health benefits. The AMA opposes preexisting condition limitations.

**Risk Pools** - Legislatively created programs that group together individuals who cannot get insurance in the private market. Funding for the pool is subsidized through assessments on insurers or through government revenues. Maximum rates are tied to the rest of the market. The AMA supports risk pools to help fill any gaps in access to health coverage.

**Single Payor System** - A single, government fund pays for everyone's health care using tax revenue. The AMA opposes shifting total control of payments to the government where budget pressures would decrease choice and quality of care to patients.

**Small Market Insurance Reform** - Changes in the marketing of insurance to small businesses that increase the availability and affordability of coverage. The AMA supports market reforms that eliminate preexisting condition limitations, institute community rating, and make health insurance portable.

State Mandated Benefits Laws - State laws requiring insurance contracts to provide coverage for certain health services (e.g., in vitro fertilization) or for services provided by certain health care providers (e.g., audiologists). Self-insureds are exempt from these requirements. There are over 800 mandates nationwide. The AMA supports repeal of these laws and establishment of a federal basic benefits package to improve the availability and affordability of insurance.

Tax Incentives - Tax deductions, credits, and rebates affecting insurance benefit decisions. The AMA supports tax changes to help small businesses. To avoid overinsurance, AMA supports a tax cap to limit employers' deductions for health benefit premiums and tax exempt rebates for employees choosing economical insurance plans. Out-of-pocket payments should be tax deductible by the employee. Self-employed individuals should get comparable tax deductions for the insurance contributions.

**Uniform Claim Form** - All insurers and self-insurers would be required to use a single claim form and standardized format for electronic claims. The AMA supports a uniform claim form to reduce administrative costs.

**Uninsured Population** - An estimated 34 million Americans. 56 percent are workers. 28 percent are children. 16.5 percent are nonworking adults. 83 percent of workers have private health insurance.

Universal Access - Access to health insurance coverage for everyone. The AMA supports universal access as an essential part of reform. This is best accomplished through a combination of private and public sector coverage. Employer-provided insurance, government programs, tax reform, and insurance reform will make affordable insurance to everyone.

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**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug. <sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally. <sup>1,3</sup>

**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence. 1.3.4 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks. 3

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10

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#### "The Masters Series"

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Presented by Michigan State Medical Society in cooperation with Michigan Physicians Mutual Liability Company

#### **Managed Care in Michigan:** The New Architecture of Health Care Delivery

Thursday, January 13, 1994 8:30 a.m. to 4:30 p.m. Embassy Suites Hotel, Southfield \$170 members/\$255 others

This conference will provide insights into evaluating and negotiating managed care contracts and understanding capitated payment arrangements. Michigan managed care trends — including utilization management, quality assurance and credentialing activities — will be discussed. The conference also will explore how medical relationships are being re-evaluated and re-negotiated in managed care.

#### POs/PHOs: From Cutting Edge to Reality

Friday Evening and Saturday, February 25-26, 1994 Ritz Carlton Hotel, Dearborn \$225 members/\$350 others

This conference will pick up where last year's successful event left off, looking at the Clinton reform plan and how POs/ PHOs will fit in to the new order in health care. Managed care expert Nathan Kaufman will describe successful Physician Organizations at the national level, while local and other national experts will cover the "nuts and bolts" of setting up a PO/PHO in your community.

#### **Antitrust/Negotiations/Conflict Resolution** Conference

In conjunction with the MSMS Joint Section Meeting Friday, March 11, 1994 3 p.m. to 6 p.m. Ritz Carlton Hotel, Dearborn \$95 members/\$140 others

Ritz Carlton, Dearborn \$95 members/\$140 others

\$170 members/\$255 others

This conference will focus on key anti-trust issues physicians need to be aware of in establishing a PO/PHO and other integrated delivery systems including price-fixing, group boycotts and monopolies. Experts also will cover the importance of negotiation and conflict resolution among physicians and between physicians and hospital administrators and other health professionals. A strategy for developing physician leaders will be discussed.

#### **Control Your Future, Control Your Data: Physician Data Requirements Conference**

Thursday, April 21, 1994 8:30 a.m. to 4:30 p.m. Embassy Suites Hotel, Southfield \$170 members/\$255 others

Because of changes in technology, it is now possible to process data into usable information regarding outcomes and costs. With the increased need to do more with fewer resources, it becomes even more imperative. This conference will review how employers and payers are comparing practice patterns and comparing costs, what types of information consumers need to make informed choices and how electronic data interchange will affect physicians in their daily practice.

#### **Credentialing Conference**

May 1994, Lansing, Michigan

Speakers, sponsors and details to be announced

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| "The Masters Series"   | Cornerstones to Succes          | Please Type or Print                            |                 |
| Check boxes for conferences you plan to attend.  | Payment                         |   |                 |
| Managed Care in Michigan January 13, 1994 Embassy Suites, Southfield \$170 member/\$255 others | ☐ Member ☐ MSMS ☐ MAOPS ☐ MMGMA | Name of Attendee (to register more than one per | son -copy form) |
| □ PO/PHO: From Cutting Edge  | ☐ Non-Member                    | Practice / Hospital / Organization Name         |                 |
| to Reality February 25-26, 1994  | ☐ Check (Payable to MSMS)       | Carried Tide                                    |                 |

Specialty / Title ☐ Visa ☐ MasterCard Ritz Carlton, Dearborn \$225 members/\$350 others Address Antitrust/Negotiations/ Card No. **Conflict Resolution** March 11, 1994

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Authorized Signature Phone # Control Your Future, **Control Your Data** Total \$ ☐ Please contact me regarding special accommodations. 🕭 April 21, 1994 **Register Now** Embassy Suites, Southfield

Credentialing Conference 517-336-5797 517-336-5784 May, 1994 Lansing, Michigan MICHIGAN STATE Speakers, sponsorship and Michigan State Medical Society details to be announced. 120 W. Saginaw, P.O. Box 950, East Lansing, MI 48826-0950

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# Want to maintain autonomy and control? Create a PQ or PHQ

#### MSMS stands ready to assist you

By William E. Madigan Executive Director, Michigan State Medical Society

ising health care costs are causing businesses, state and federal governments, and insurance companies to demand more accountability and efficiency from physicians and hospitals. The result is a trend toward capitation and large, vertically integrated delivery systems. The Michigan State Medical Society strongly supports the development of physician organizations (POs) and physician-hospital organizations (PHOs) as means for physicians to appropriately address these fundamental changes. MSMS is educating Michigan physicians concerning the changes and is actively assisting physicians in creating POs and PHOs, entities which will help physicians maintain more autonomy and control over the practice of medicine.

#### Physicians have choices

Physicians have several choices in responding to the fundamental changes that are occurring in the health care delivery system. One choice is to simply ignore the changes and hope they do not affect their practice. This is an extremely dangerous choice because it will likely result in the physician losing increasing numbers of his/her patients to large delivery systems. Another alternative is for a physician to become an employee of a hospital or health maintenance organization. Many physicians are opting for this alternative because it seems to offer some security in this rapidly changing environment. However, many physicians are not comfortable with being an employee. Physician organizations allow these physicians the opportunity to become part owners of integrated delivery systems.

MSMS has defined a physician organization as "a business entity formed by a group of physicians to pursue managed care contracting opportunities and other cooperative ventures, either independently or in cooperation with a hospital or other entity." It is important to keep in mind that a physician organization is a business entity; thus, it is separate and distinct from the hospital medical staff or medical society.

MSMS has identified two major PO models: a network model and a group practice model. The PO network model allows physicians to come together to take advantage of managed care contracting opportunities as a group. At the same time, it permits them to maintain their separate practices for other patients. Under the PO group practice model, physicians merge their practices to become one economic unit. The Mayo Clinic and The Permanente Medical Group are two well-known examples of the PO group practice model.

#### A PO has many advantages

A PO has many advantages for physicians. First, a PO is responsive to the interests of businesses, state and federal governments, and insurance companies in wanting more accountability and efficiency from physicians. Second, a PO allows physicians to pursue managed care contracting opportunities either with a hospital or independent of a hospital. Third, a PO ensures that physicians, themselves, make the critical decisions concerning credentialing, utilization, management, and quality assurance. Fourth, a PO enables physicians to unite behind common goals and, thus, can be an effective defense against "divide and conquer" strategies by hospitals and payers. Fifth, a PO can result in increased efficiencies through the use of centralized management information systems. Finally, a PO should result in more effective physician representation in a PHO by ensuring that the physician representatives on the PO board represent all PO members, not just themselves.

#### POs and PHOs go hand-in-hand

Once physicians have created a PO, it is likely that they will want to establish a PHO. A PHO is a business entity formed jointly by a group of physicians and a hospital or hospital system in order to pursue one or more cooperative ventures. The major advantage of a PHO is that it allows a group of physicians and a hospital to become a single, integrated negotiating entity that can compete more effectively for managed care contracts than either could by negotiating separately with payers. A PHO allows physicians to work with a hospital as equal partners in delivering health care services. In establishing a PHO, it is not necessary for physicians to merge their practices or to merge with a hospital.

Continued on following page

Continued from page 27

#### MSMS offers several conferences

MSMS has undertaken many initiatives to educate its members concerning the changes that are occurring in the health care system and how POs and PHOs can help physicians effectively address these changes. First, in May, 1993, MSMS held a seminar concerning POs/PHOs for a group of approximately 80 physician leaders. Second, MSMS conducted a series of 10 seminars throughout Michigan during the summer of 1993 concerning health system reform and POs/PHOs. Nearly 300 physicians attended these seminars. Third, we are holding a series of major conferences concerning health system reform called the "Masters Series." (See page 26 for a complete list of conferences.) The first conference titled "POs/PHOs: Cornerstones to Successful Health Care Reform," was held on September 10-11, 1993. Over 250 physicians and hospital administrators attended the conference at which several national experts spoke.

MSMS also has created a new division called Physician Organization and Management Services (POMS) to provide hands-on assistance to physicians in the development and operation of POs and PHOs. All POMS services are provided by "physician friendly" expert consultants. The major services available through POMS include business planning, environmental analysis, legal, and management information

systems. POMS is already working with several groups of Michigan physicians to help them develop POs. We anticipate assisting many other groups over the next several months and years.

We also have developed a sophisticated slide presentation concerning POs/PHOs which we have shown to many physician groups throughout Michigan. In addition, MSMS is making available to its members videotapes of experts speaking about health system reform changes and POs/PHOs.

In conclusion, MSMS believes strongly that fundamental changes are occurring in the US health care delivery system. In our view, POs and PHOs represent an opportunity for physicians to assert leadership and become owners of an integrated delivery system. MSMS not only is educating Michigan physicians concerning the changes in the health care delivery system, but also is actively assisting its members in creating POs and PHOs.

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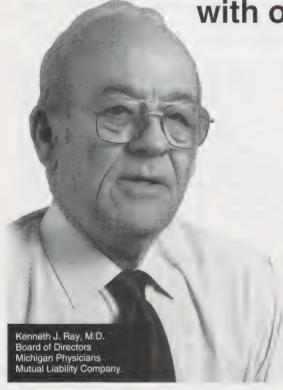
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## **POs and PHOs:**

## A Paradigm Shift for Physicians

By William J. Carbone

ithout a doubt, intense competition for managed care contracts is underway, and physicians are a critical commodity in the managed care market-place.

Some physicians may feel their options are now shrinking; others may see more options than ever before. So says the AMA in the September 1993 issue of its *Medical Staff Legal Advisor* newsletter. No matter what perspective a physician may have, reports the AMA, "all physicians must have information necessary to determine the course of action that will best serve their interest..."

The MSMS Physician Organization and Management Services (POMS) division is providing physicians with the information they need. More importantly, it is showing physicians how to use this information to determine their best possible course of action. Going one step further, MSMS is helping physicians develop physician organizations (POs) and physician-hospital organizations (PHOs) – effective organizations which will ultimately benefit both physicians and patients.

There will be winners and losers under health system reform, but the winners will be those physicians and organizations who have effectively transformed chaos into opportunity.

#### Physicians have choices

There is no question that physicians have choices – and MSMS/POMS stands ready to help physicians identify the best choices. MSMS/POMS strives to position physicians in proactive, rather than reactive roles. A full-page ad published in a recent issue of *The Wall Street Journal* said it best: "Act Today or React Tomorrow."

There is no correct or incorrect choice concerning this issue. It is up to each one of you to make your own decisions. However, I must remind you that, in positioning yourself for health system reform, you must concern yourself with the issue of control. The options are clear: You either control or be controlled; manage or be managed.

In my experience, the vast majority of physicians involved in the development of POs and PHOs do not really feel that their options are shrinking. Rather, they see more options than ever before and are prudently preparing themselves to take advantage of these opportunities. There is no question that—at a very minimum—being prepared for early entry into a new health care environment will position the proactive physician and his or her organization to enhance market share opportunities. There will be winners and losers under health system reform, but the winners will be those physicians and organizations who have effectively transformed chaos into opportunity. By being proactive, physicians, hospitals, payers, employers, and suppliers will all move forward in an effective and collaborative fashion.

#### It's not too soon to act

There are numerous questions physicians pose concerning physician organization and physician hospital organization development. One question that is often asked is, "Are we moving too quickly?" No, I don't believe we are. This can be supported by a recent article published in *The Wall Street Journal*. The article concerned the merger between Columbia HealthCare and HCA-Hospital Corporation of America – a \$5.7 billion dollar deal which merged the nation's two largest for-profit hospital chains.

We're talking revenues in excess of \$10 million, 190 hospitals with more than 42,000 beds in 26 states and two foreign countries, in addition to 125,000 employees. While this alone is impressive, what is more impressive is the speed at which this decision was made. According to *The Wall Street Journal*, it only took these companies *three weeks* to make this monumental decision. I think this answers the question as to whether MSMS/POMS is moving too quickly.

Another example of the speed at which we are seeing physician organizations and physician-hospital organizations develop can be evidenced by a report entitled, "Hospital-Physician Integration, Results of a National Survey," published in June, 1993, by the Academy for Health Services Marketing, Ernst & Young, and the Report on Physician Trends. This is an excellent 12-page quick-read document. According to the report: "More than half of the physician

Continued on following page

Continued from page 29

arrangements in existence today were created within the past 18 months. A majority of hospitals without such an arrangement plan to develop one within the next two years." There is little doubt that we will see an even more rapid growth of POs and PHOs within the next year. MSMS, through its Physician Organization and Management Services division, wants to make certain that those physicians who are interested in creating such entities have access to the best assistance available.

#### A paradigm shift

The development of physician organizations and physician-hospital organizations is a paradigm shift for physicians

and all those involved in their development. A paradigm is like a map, a pattern or a new way of thinking. MSMS - through its POMS division -- is providing that new map, that new way of thinking for physicians. If we want to make minor changes in health system reform, we can change our behavior and attitudes, but if we want to make major changes in health system reform, we must change our paradigm - our way of thinking. And, if we use the current map or pattern, no matter how hard or quickly we endeavor, we will never get to where we want to be because we will be on the wrong map.

#### MSMS offers expert assistance

As part of this complicated process, MSMS is assisting physicians to manage through change. We have clearly established that change in the health care sector is occurring at incredible speed, and there is a natural inclination for us to react and try to modify the change. This would be

a fatal mistake and doom us to disaster. In 1993, MSMS/ POMS staff has provided almost 100 presentations to physicians and physician groups throughout Michigan concerning the development of POs and PHOs. The response has been extremely positive and well-received by physicians from all specialties and all types of practices. It continues to be a very satisfying and enjoyable process to assist physicians to manage through change for the ultimate benefit of their patients.

POMS presently is working with hundreds of physicians developing POs and PHOs, and the pace is quickening daily. Proposals have been sent out to physician groups numbering 25 to 750 for both the development of POs and PHOs. Each group, irrespective of its size, receives the same

attention and service.

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MSMS/POMS is of the opinion that physician organizations must be created prior to physician-hospital organizations. We believe there are at least six good reasons. including but not limited to:

- the advantage of unifying physicians;
- the potential for an independent business opportunity;
- placement of physicians in control and management as opposed to being controlled and being managed;
- the benefits of economies of scale;
- an active/proactive strategy; and
- effective defense against divide and conquer strategies.

Since the creating of POs is so important, an article on this topic will gan Medicine.

ing to see physicians come together in strong and cohesive arrangements, enhancing trust and collegiality, which also are keys to a strong physician organization and physician-hospital organization.

MSMS/POMS is unique in providing this specialized service to physicians. We are here today and we are going to be here tomorrow. In addition, we have the highest degree of trust and collegiality and we have the physician's best interest at heart. Furthermore, MSMS/POMS is flexible and adaptive - we know that each PO/ PHO is different. Finally, MSMS/ POMS understands physicians best better than anyone else. These are priceless advantages to using the ser-

organization development today and tomorrow.

No other medical association in the United States is taking such a leadership role for its members. If you would like to learn more about the services available, please contact us. We will be glad to provide you with a presentation and stand ready to assist you in any way we can.

be featured in a future issue of Michi-Through this interesting process of PO and PHO development, it is satisfy-

wrong map. vices of your medical association. Where physicians are looking for leadership, MSMS is fulfilling that need in a manner befitting the medical profession. In 1994, we will see the development of more POs and PHOs under the auspices of the Physician Organization and Management Services of the Michigan State Medical Society. POMS provides a full spectrum of services and physician organization and physician-hospital

> Bill Carbone is chief, Physician Organization/Physician-Hospital Organization Development, MSMS Physician Organization and Management Services.

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If you're a member of the Michigan State Medical Society and you'd like to know more, just write or call:

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East Lansing, Michigan 48826-0950
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The future of healthcare demands a different type of delivery structure...

-Edward B. McRee, President

Change is never easy, especially when it involves a whole community. When we merged Ingham Medical and Lansing General last December, we knew we were taking a big step. Both for ourselves, and for the people of Lansing.

This historic merger created a network of 700 physicians, 1,000 nurses, 2,000 health professionals and dozens of community-based services. At the heart of our new system is **Michigan Capital Medical Center**, a hospital with 483 beds on two campuses.

At Michigan Capital Healthcare, our new name is only the beginning. Benefits from further cost-reduction and elimination of duplicated services will continue to grow, while new efforts at cooperation and improved service delivery reshape our healthcare future.

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## **Your Guide to Federal Legislators**

TAKE TIME TO SHARE YOUR VIEWS ABOUT HEALTH SYSTEM REFORM

hanges are ahead for physicians, as this issue of *Michigan Medicine* shows. If you have concerns about health system reform, take a few minutes to write or call your legislators. Ask your patients to write or call, also. Take the time to get involved. It's the best way to ensure that your concerns are heard. Following is a complete list of federal legislators. If you have any questions, or would like more information on how to contact your Michigan Congressmen and Senators, please contact Kevin A. Kelly, MSMS Assistant Executive Director, at 517-336-5743.



The Honorable Bob Carr (D-East Lansing) U. S. House of Representatives 2439 Rayburn Building Washington, DC 20515 (202) 225-4872



The Honorable James Barcia (D-Bay City)
U. S. House of Representatives
1719 Longworth Building
Washington, DC 20515
(202) 225-8171



The Honorable Barbara Collins (D-Detroit)
U. S. House of Representatives
1541 Longworth Building
Washington, DC 20515
(202) 225-2261



The Honorable David Bonior (D-Mt. Clemens)
U. S. House of Representatives
2242 Rayburn Building
Washington, DC 20515
(202) 225-2106



The Honorable John Conyers, Jr. (D-Detroit) U. S. House of Representatives 2426 Rayburn Building Washington, DC 20515 (202) 225-5126



The Honorable Dave Camp (R-Midland) U. S. House of Representatives 317 Cannon Building Washington, DC 20515 (202) 225-3561



The Honorable John D. Dingell (D-Trenton) U. S. House of Representatives 2221 Rayburn Building Washington, DC 20515 (202) 225-4071

Continued on following page

#### Continued from page 33



The Honorable William Ford (D-Ypsilanti) U. S. House of Representatives 2371 Rayburn Building Washington, DC 20515 (202) 225-6261



The Honorable Nick Smith (R-Addison) U. S. House of Representatives 1708 Longworth Building Washington, DC 20515 (202) 225-6276



The Honorable Peter Hoekstra (R-Holland) U. S. House of Representatives 4401 Longworth Building Washington, DC 20515 (202) 225-4401



The Honorable Bart Stupak (D-Menominee) U. S. House of Representatives 317 Cannon Building Washington, DC 20515 (202) 225-4735



The Honorable Dale Kildee (D-Flint) U. S. House of Representatives 2239 Rayburn Building Washington, DC 20515 (202) 225-3611



The Honorable Fred Upton (R-St. Joseph) U. S. House of Representatives 1713 Longworth Building Washington, DC 20515 (202) 225-3761



The Honorable Joe Knollenberg (R-Bloomfield Hills)
U. S. House of Representatives
1218 Longworth Building
Washington, DC 20515
(202) 225-5802



Senator Carl Levin (D-Southfield) United States Senate Russell Senate Office Building Washington, DC 20510 (202) 224-6621



The Honorable Sander Levin (D-Southfield) U. S. House of Representatives 323 Cannon Building Washington, DC 20515 (202)225-4961



Senator Donald W. Riegle (D-Flint) United States Senate SD 105 Dirksen Senate Office Bldg Washington, DC 20510 (202) 224-4822

### What is AMA/MSMS P.O.W.E.R.?

#### Physicians Organized to Work for Effective Reform

**P.O.W.E.R.** is the American Medical Association's/Michigan State Medical Society's legislative and political grassroots network. It is designed to provide AMA/MSMS members and their families the tools necessary to communicate with their Senators and Representatives on the many issues surrounding the debate on health system reform.

**Physicians** are the most important link in the AMA/MSMS legislative and political grassroots chain and members of Congress will be reaching out to their physician constituents for advice. Physicians must be ready to give that advice.

**Organized** efforts are the key to any campaign. The legislative and political grassroots programs outlined in this article will provide ample opportunity for physician constituents to develop long-term relationships with their Representatives.

The **Work** necessary to develop these relationships must be shared by many, as **every** physician has a stake in health system reform

**Effective Reform** will put patients first; it will protect the physician-patient relationship; it will allow physicians and patients to make the clinical decisions in the best interests of the patient, not the plan; it will free physicians to practice medicine rather than accounting; and it will lift the cloud of frivolous lawsuits that hangs over the physician-patient relationship.

For physicians and their families, legislative and political grassroots action has never been so important. With the introduction of the President's plan for health system reform, along with numerous other bills all aimed at a major overhaul of the nation's health care delivery system, the U.S. Congress will be making fundamental changes in the lives of physicians their families and their patients.

Members of the AMA/MSMS P.O.W.E.R. Network will receive the latest inside information on health system reform on other legislative issues important to organized medicine and timely political updates as well.

But most important members of the AMA P.O.W.E.R. Network will be called upon to build the relationships and ultimately seek support for the views of organized medicine.

Join the AMA/MSMS P.O.W.E.R. Network today. Your participation will make a difference for you, for your family, for your patients and for the future of health care in this country.

#### How Does AMA/MSMS P.O.W.E.R. Work?

The AMA/MSMS Congressional One-on-One Program — It is essential that the AMA/MSMS and physicians across the nation have access to the Members of Congress who will be deciding the ultimate direction and the ultimate fate of health system reform. But access is based upon relationships — and relationships are not built overnight. Rather the strongest relationships are built on trust over time. The AMA/MSMS Congressional One-on-One Program creates an environment in which such relationships will grow.

- You will be notified of the date, time and location for the Congressional One-on-One meeting in your area. As the meeting approaches, materials will be provided to update you on the latest health system reform developments in Washington.
- Prior to the meeting, you will be briefed by the One-on-One District Chair in your area on the goals for the meeting and subjects for discussion.
- The results of the meeting will be shared with the state medical society and the AMA lobbying team in Washington, D.C.

AMA/MSMS Calls to Action - As the need arises, you will be asked to write or call your Senators and Representative on timely issues important to organized medicine. As a member of the AMA/MSMS P.O.W.E.R. Network, you will be called upon to speak with members of Congress seeking their support for organized medicine.

Your State Medical Society - Members of the AMA/MSMS P.O.W.E.R. Network may be called to lobby not only their federal representatives, but state legislators as well. Meeting with state legislators, working political campaigns, writing or phoning your local legislator, and participating in "mini-internships" are just a few of the many ways you may be called to act.

Join the AMA/MSMS P.O.W.E.R. Network today!

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|  |                                  |  |
| or U.S. Representative:  |                                  | Have you ever worked, either as a volunteer of otherwise, in a political campaign?   |
|  |                                  | Have you ever worked, either as a volunteer of otherwise, in a political campaign?   |
| or U.S. Representative:yes, please describe:   |                                  | Have you ever worked, either as a volunteer of otherwise, in a political campaign? ich you would be interested in participating:                                     |
| or U.S. Representative: yes, please describe: Please indicate the legislative and politi | ical grassroots activities in wh | Have you ever worked, either as a volunteer of otherwise, in a political campaign?  ich you would be interested in participating:  Congressional One-on-One Meetings |
| or U.S. Representative: yes, please describe: Please indicate the legislative and politi | ical grassroots activities in wh | ich you would be interested in participating:  |

# MSMS/AMA offer tools for educating patients

MSMS and the AMA are combining forces to give every Michigan physician the tools to inform their patients of the ramifications of proposed health system reform.

You need only complete and mail this order form to obtain the tools to discuss and explain the proposed changes to your patients, your colleagues, your family and your friends. The materials listed below come from the AMA and MSMS. They will be supplemented as the reform debate continues.





"We may not be experts in economics but we are experts in patient care. And it's important that our patients know what's going to happen to them."

> -James S. Todd, MD AMA Executive Vice President

| uantity   | Cost              | Quantity  | Cost     |
|---|-------------------|---|----------|
| "Think about it! 10 Questions Bookmarks" Bookmarks offer 10 basic questions public should raise about proposed reforms. AMA and MSMS seals imprinted.  \$49/1,000 plus \$3/1000 shipping  "Think about it! 10 Questions Posters"  | \$                | "Integrated Systems: Myths and Realities" One-hour videotape of Jeff Goldsmith's presentation at MSMS/MPMLC PO/PHO Conference September 10-11 in Southfield.  \$95  "Keys to a Successful PHO"One-hour video-   |          |
| 16" x 22" posters for office, clinic offer 10 basic questions public should raise about proposed reforms. AMA and MSMS seals imprinted.  "How Will Clinton Health Reform Proposal Affect You and Your Family?" Four-page brochures for office and clinic analyze Clinton plan based upon 10 basic questions public should raise about proposed reforms. AMA and MSMS seals imprinted.  \$1 for packs of 25, minimum order five packs  "The Role of the Physician in Health Care" 32-page special issue of Business and Health magazine positioning physician as key player in health care delivery. For office and clinic display. MSMS and AMA seals imprinted.  \$1 each, minimum orders of 100  Copies of AMA and MSMS analyses of plans proposed by Clinton Administration, U.S. Republican and Democratic parties and state legislators.  Free | <b>5</b>          | tape of Nathan Kaufman's presentation at MSMS/MPMLC PO/PHO Conference September 10-11 in Southfield. \$95  Five PO/PHO organizational experts one-hour videotape of presentations at MSMS/MPMLC PO/PHO Conference September 10-11 in Southfield. \$75  Package of three videotapes above from MSMS/MPMLC Southfield Conference on POs/PHOs. \$225  35-minute speech/slide show analysis of Clinton plan and other proposals on rotating loan  Compendium of MSMS and AMA policies regarding health system reform. \$5 per copy  "A Review of the Health Status of Michigan's Citizens." Comprehensive document with executive summary, describing role of Michigan citizens' poor health status on rising health care costs. Free | \$<br>\$ |
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| ease enclose check or money order with your order d mail to MSMS, Communications Department, D Box 950, East Lansing, MI 48826-0950. Or fax ur order to $517/337-2490$ .  Check/Money Order $\square$ Visa $\square$ MasterCard   | Telephone Address |   |          |
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Soundoff! provides you with the opportunity to voice your opinion about any issue you please. If you have an opinion you would like to share with your colleagues, write it down and send it to *Michigan Medicine*, PO Box 950, East Lansing, MI 48826-0950 Attn: Betty McNerney. We will do our best to publish your comments in a timely manner.

By Gene Ragland, MD

#### Health System Reform: On With the Show

Editor's Note: The following article appeared in the October 1993 issue of the Washtenaw County Medical Society *Bulletin*.

urry, hurry, hurry," shouts the barker. "The Clinton Health Reform Review is about to begin." Like the carnival sideshow, warm-up acts have teased since the inauguration with glimpses of what's inside. Soon the wraps will come off and the health reform plan will be fully exposed for all to see.

The show is a sellout. The audience is packed. Congressmen sit in the front rows, Republicans on the right and Democrats on the left, with tickets purchased for them by their lobbyist friends. Next come the insurance company executives. A few of them from the big companies helped to write the show. The HMO executives in the audience have furrowed brows. They've heard that the plan will require them to open their HMOs to everyone, not just the young and the healthy.

Businessmen of all kinds are scattered throughout the audience. Pharmaceutical representatives, medical suppliers, trial lawyers, and corporate attorneys anxiously await the production to come. Auto executives are thinking about the \$1,200 per car that health care costs add to the price of their

product. They wonder how they can remain competitive in a world market. Will they have to further "out source" or move manufacturing to Mexico or Asia where health care is in less demand and less expensive?

The auto executives are flanked in the side seats by leaders of the UAW which has been labeled "the last bastion of free health care." Their pre-show musings center on contract talks with the Ford Motor Company. They know that Ford workers received \$19.24/hr in benefits last year in addition to an average hourly wage of \$19.92. How will the 400,000 UAW members react to a reduction in health benefits or to a copay requirement?

Small businessmen are all sitting on the edge of their seats. They've heard that the plan will require them to provide mandatory health insurance, to pay 80% of employee health insurance costs. A critic from their 500,000 member National Federation of Independent Business has already given a negative pre-show review unalterably opposing any government mandate to provide coverage.

Near the back of the audience sit the leaders of the AMA and organized medicine. Their offer to act as consultants on the plan has been rejected by the show's director Hillary Rodham Clinton.

The patients sit in the back of the audience. Some are dozing, apparently unaware that the plan will affect them. A large block of gray-haired patients sit together, guests of the AARP. These senior citizens are alarmed at reports of substantial cuts in the Medicare program that covers 31 million elderly and

four million disabled individuals. On the outside looking through the windows, are those who couldn't afford the price of a ticket. They are hopeful as they've heard rumors that they might be invited inside.

Uncertainty fills the air. Will the show be a morality play, a tragedy, theater of the absurd? Will the expectations be greater than the realization? The houselights dim, the national spotlight focuses on the stage as the curtain rises.

The show opens with a group of mostly men sitting in a large living room engaged in animated conversation, wringing their hands and gnashing their teeth. Out the large picture window in the background loom large mammary-like mountains. Why it's the Grand Tetons and this must be Jackson Hole!

The group consists of insurance executives, health care consultants from think tank organizations drug, hospital and big business executives, a doctor or two and a few academics. At the head of the gathering sits Alain C. Enthoven, economics professor from Stanford University and long-time consultant to the Kaiser Permanente Medical Care Program.

"We're here to talk about what's wrong with the health care system and to come up with a model for reform," says a vice-president for public policy at InterStudy, a health policy research organization The meeting is being hosted in the home of the president of InterStudy, Dr. Paul M. Ellwood Jr. "As I look around this room," Ellwood

Continued on following page

Continued from page

observes, "the people here are responsible for the health care of about 180 million Americans. If you people can't come up with a template for reform, then somebody else who may be less familiar with how the system operates will develop it for us."

"Well, Professor Enthoven," says one of the assembled, "as you know we all have a special interest in the U.S. health care system. What's wrong with the system and what can we do about it?" "It costs too much and it's not available to everyone," asserts the learned professor. "Health care in the United States cost \$920 billion last year, about 14% of the GDP, not to mention another \$10.3 billion paid out of pocket for alternative medical care. As you know, 37 million Americans do not have health care insurance, 20 to 30 million Americans are inadequately insured and five million women in this country are without prenatal or child delivery insurance coverage. Further," he continues, "the only legally mandated access point to the health delivery system is through emergency. We must design a system that controls health costs and provides insurance to all citizens."

"How can we afford the cost of caring for everyone? That would be prohibitively expensive," echoes the group. "We must begin at the beginning," answers the professor, "by rationing the health care available to patients. We will design a uniform basic benefits package to be offered. If an employer provides additional insurance benefits, the cost of those benefits will be taxed. Consumers can obtain additional individual benefits and noncovered services by paying for them. It's the American way, you know."

"We see, we see, well we agree," singsongs the chosen few. "We are trying to control costs," pleads an indemnity insurance executive. "We already limit benefits and require copays and deductibles. We utilize rating practices, deny coverage for pre-existing conditions, require precertification approval, retrospectively deny payment

for rendered services and cancel policies when large claims are made."

"That's cost shifting and inconsistent with the goal of providing basic care to everyone," points out the academic. Enthoven proceeds, "if we use a single payer system, such as the one currently in effect in Canada, we can eliminate 1,500 competing insurance companies and save up to 10 percent in health coverage costs. Further, we can regulate medical fees by direct government controls on payments to physicians and hospitals."

"Oh no, oh no," gasps the group. "That would be un-American; we must preserve private enterprise." "Well," intoned the economist. "There is another way. A way to provide universal coverage, privately provided and publicly guaranteed." "A way, a way," sings the group. "He knows a way to save the day. Hooray, hooray; show us the way to save our pay." The first musical interlude of the show provides a welcomed respite from the preceding dialogue. Smiles and backslapping ripple around the room. "What is the way? Is it play or pay or do you know another way?" ends the refrain.

"Managed competition! Managed competition is the way! Structured competition within the private sector." Now angelic voices fill the auditorium and in the background the sun breaks through the clouds and shines brightly on the mountainous projections as the curtain falls.

Act II opens with Professor Enthoven explaining the intricacies of managed competition to the Jackson Hole Group. "Managed competition will require a restructuring of the health care system that is unprecedented in the U.S.," he explains. "We must integrate the financing and delivery functions of medical care. The relationships among patients, payers and providers must be recognized and recast as to their respective roles. As applied to practitioners such as physicians, medical groups, hospitals and other health care entities they will be divided into competing economic units called accountable health partnerships. They will contract with health insurance purchasing cooperatives to provide standardized packages of medical benefits for fixed per capita rates."

"Fixed rates?" chokes the doctor. "All we want is fee-for-service and the right to choose the care that's best for our patients." "Fee-for-service is dead," pronounces Enthoven. "Since the inception of risk pooling and insurance plans in the '30s, providers have been insulated from direct economic consequences of their medical decisions. With limited, fixed dollar amount remuneration, providers will bear the economic consequences of their choices more directly. They will bear financial risk for their performance. You will still have choice. The choice to do or not to do a particular test or treatment."

"What about patient satisfaction; what about malpractice exposure if I miss something?" queries the doctor. "Patients will all be treated alike. They will receive the same basic benefits. If they choose, they can receive health care outside the plan if they pay for it. Immunity from malpractice will be provided to you if you adhere to established, cost-effective practice guidelines. We understand that you can no longer be held accountable for diagnosing the rare disease or saving the high risk patient. We just can't afford it," comes the reply.

"Look at it this way. Here's a chance to reassert the primacy of the clinical encounter, an opportunity to use your knowledge and experience to make a clinical decision without unnecessary testing or consultation. The generalist physician will be given the first opportunity to provide care and to control the expenditure of limited monies," adds a health care consultant.

"I'm beginning to get the picture," responds the doctor. "How will the money be divided among the various providers?" "I thought you'd never ask," said the consultant, "by managed cooperation, of course." "What's the role of preventative medicine in this system?" inquires the M.D. "We will pay for preventative medical care. We all know that prevention of illness and

injury is the single best way to reduce long-term health care costs. However, do you really think doctors are going to learn about nutrition? Do you expect people to stop smoking, drinking alcohol, taking drugs and overeating? Do you think they will take their medications, exercise regularly and wear their safety belts?" explains an academic.

"Just one more question," says the doctor. "What about quality? How will you insure quality care with limited resources?" "That's easy," comes the quick response. "No one knows how to measure quality. We used to stress process; now we'll focus on outcome." The group becomes excited. They all stand in unison and link arms prancing in lock step across the stage. Lights flash and sparkles fall from the sky creating a halo above the mountains. Here it is, the big production number. It is clear that no expense has been spared to promote this concept.

"More for less, more for less," sing

the convinced. "How we'll do it is a guess. How you define it, that's the test. Just believe it, more for less." The action stops but the music carries on . . . "more for less, more for less." The group has been lip-synching to a broken record. The curtain falls.

Act III opens in a smoke-filled room. It's Hillary and the White House task force appointed to design the health care plan. Government analysts, bureaucrats, congressional staff members and independent consultants are gathered in groups. In one corner, the pharmaceutical lobbyist proposes a voluntary program under which each company's annual average price increase for drugs will be limited to the rate of inflation. In another, the American College of Physicians proposes a universal system of insurance with a ceiling on total health expenditure, a socalled "global budget." The American Academy of Family Physicians readily endorses that approach. A representative of the AMA signals willingness to accept spending limits and the creation of a national health board to oversee the new system. Everyone is cutting a deal, lining up to be a part of the new health reform plan. In the wings stand a patient and a lone physician. They talk but no one listens. Soon the stage is so full of smoke that vision is obscured. The curtain falls.

A smattering of polite applause follows as the audience files out in stunned, confused silence. Critics rush to file their reviews. Soon a low buzzing sound turns to a hum then to whispers and audible conversation and finally to loud discussion as attendees begin to exchange views and express opinions. Hope replaces despair as it's recalled that it is only opening night. There is still time to edit, to re-write the script. After all, we must do something or someone else will do it for us.

(In anticipation, September 7, 1993)

Doctor Ragland is president of WCMS and is medical director of the emergency center at St. Joseph Mercy Hospital.

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## **MSMS LEGAL BRIEFS**



Editor's Note: If you have a legal question you would like answered by MSMS legal counsel in this column, jot it down and send it to Betty McNerney, Editor of Publications, P.O. Box 950, East Lansing, MI 48826-0950

66 Malpractice reform

legislation achieved in

Michigan in Public Act

No. 78 is substantially

better than these so-called

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Data Bank disclosure

and enterprise liability.

could be detrimental.

#### **Clinton Health Plan/Malpractice and Antitrust Reform**

By Richard D. Weber

erhaps the two most significant legal components of the Clinton health plan are malpractice and antitrust reform. The following summarizes these areas, followed by a brief commentary:

#### **Malpractice Reform**

Eight topics are covered:

- Alternative Dispute Resolution: Each health plan would establish an ADR process using models developed by the National Health Board. Consumers would be mandated to submit a claim through ADR but could then pursue a complaint in court if dissatisfied.
- Certificate of Merit: An affidavit would be required of a doctor practicing in a "relevant" field attesting that he/she has examined the claim and has concluded that there was a deviation from the standard of care.
- Attorney Fees: Plaintiff contingent fees would be limited to 33-1/ 3 percent.
- Data Bank Access: HHS would establish rules for public access to information regarding providers who incur repeated malpractice judgments and settlements.
- Collateral Source: Collateral source payments would be deducted from any award.
- Periodic Payment of Awards: Either party may request that an award be made payable in periodic installments.
- Enterprise Liability Demonstration Project: Federal funds would support state demonstration projects to establish enterprise liability.
- Standards Based on Practice Guidelines: HHS would develop a medical liability pilot program based on

practice guidelines. Physicians who complied with practice guidelines would not be liable for malpractice. HHS has authority to work with states to establish legally binding guidelines.

Malpractice reform legislation achieved in Michigan in Public Act No. 78 is substantially better than these so-called reforms. Little if anything new is suggested and some areas. such as Data Bank disclosure and enterprise liability, could be detrimental.

#### Antitrust Reform

The plan would repeal the McCarran-Ferguson Act pro-

viding immunity for the business of insurance and mandates the Justice Department and FTC to develop guidelines. In addition to the repeal of McCarran-Ferguson, six topics are covered:

- **Hospital Mergers:** The Department of Justice (DOJ) and FTC would publish guidelines that provide safety zones for smaller hospital (undefined) mergers and expedited advisory opinions.
- Hospital Joint Ventures and Purchasing Arrangements: The DOJ and FTC would publish guidelines that provide safety zones for such joint ventures and arrangements involving high tech or expensive equipment and ancillary services as well as joint purchasing arrangements involving goods and ser-
- with expedited advisory opinion procedures. Within these

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■ Physician Network Joint Ventures: The DOJ and FTC would publish guidelines that provide safety zones for physician groups that do not possess market power (below 20 percent) and that share financial risk, along

#### **LEGAL BRIEFS**

Continued from page 41

yet-to-be-determined safety zones, physicians could bargain collectively with health plans about payment, coverage, decisions about medical care, and other matters without fear of antitrust violations.

- Provider Collaboration: To protect physicians and other providers from market power of third-party payors, providers are provided a narrow safe harbor to establish and negotiate prices if the providers share financial risk (which does not include fee discounting) and their combined market power does not exceed 20 percent. The safe harbor does not apply to the implicit or explicit threat of a boycott.
- **State Action Immunity:** The DOJ and FTC would publish guidelines that apply the "state action doctrine". The state must establish a clearly articulated and affirmatively expressed policy to replace competition with regulation and actively supervise the arrangements, in order for this immunity to apply.
- Provider Fee Negotiation Schedule: Alliances must establish a fee schedule for fee-for-service plans, and providers need certainty that their actions in negotiating with the plans will not violate antitrust laws. The DOJ and FTC will publish guidelines that describe under existing

law the ability of providers to collectively negotiate fee schedules with the alliances.

The repeal of the McCarran-Ferguson law would subject the business of insurance to the federal antitrust laws. This would be significant. The other proposals would change no underlying statutory law and probably do no more than reiterate existing government policy. At best, they would represent marginal improvement for physicians. The so-called "safety zones" do not adequately address the prime physician antitrust concern relative to the antitrust laws impeding physicians from taking collective actions to compete effectively with hospital and insurer-controlled plans in a reform system.

Richard Weber is an attorney with Kerr, Russell & Weber, Detroit, MSMS legal counsel.

#### **AMA Update**

Thanks to the concerted work of AMA's lobbyists, the General Counsel's Office and Legislative Activities, legislation has been recently introduced (H.R. 3486 by Representative Bill Archer, and S. 1658 by Senator Orrin Hatch) that would establish physician safe harbors. The measure will also be incorporated into the Chafee/Thomas health system reform bills. For copies of these bills, or for more information, contact Kevin A. Kelly at MSMS.

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## MSMS Reimbursement Roundup



By Joyce Nurenberg
MSMS REIMBURSEMENT OMBUDSMAN

#### Are you using your patient registration form to your best advantage?

anagement of your accounts receivable begins with complete, accurate information from the patient. To get this information, every office uses some variation of a patient registration form to capture the demographic and financial detail for new and established patients. A patient registration form also is a time management tool. How comprehensive is your form and are you using the information to your best advantage?

- A good form will include prompters. A good form will include prompters such as apartment number or lot number, policyholder's birthday, retirement date, marital status, referring physician name and work-related injury so any new, covering and veteran staff do not have to remember to ask. As a result, staff can concentrate on sharpening their investigative skills to determine whether the information is complete and accurate.
- Allow space for multiple insurance plans. As it is common to treat a patient covered under multiple insurance plans, having the capability to record at least three insurance plans is important. Three dedicated areas make it cleaner to update records should insurance plans change. It is important to keep prior insurance information on file because accounts often carry balances owed by insurance that expire. Since copies of insurance cards are taken, your form need not include space to record insurance addresses.
- Have separate section for financial responsibility. Your registration form should have a separate section for financial responsibility. The holder of insurance and the guarantor of the account should not be the same unless the patient is 18 years of age or older and also is the insured.
- **Get employment information.** A question about whether a patient can be contacted at work can be useful to confirm appointments, give lab results and to discuss status of the account. Employment information on policyholders provides an alternative source for insurance matters when the employee can not be reached.

- Emergency contacts serve many functions. Space for a name and phone number of at least one emergency contact not living at the same residence will provide a resource if your office receives returned mail or encounters a disconnected phone number. This also can provide an information source if wrong or incomplete information is given or staff records the information incorrectly.
- Have patients complete form prior to office visit. As a time management tool, it is easier to ask patients to complete the form prior to their appointment. They will appreciate not being asked to come in 10-15 minutes early to fill out paperwork. If you have the information returned prior to the appointment, staff will be able to construct a chart beforehand thus keeping the pace of the workflow from becoming too hectic.
- Combine assignment of information, signatures. Time and paper can be saved by combining the assignment of benefits and guarantor information and signatures on the same form.
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Krishna Sawhney, M.D.,F.A.C.S., President, International College of Surgeons, Michigan Division, Chief of Surgery, Downriver Region, Henry Ford Health Systems and Heritage Hospital, Taylor, MI, Clinical Associate Professor of Surgery, Wayne State University, School of Medicine, Detroit, MI

**Eduardo Phillips, M.D., F.A.C.S.,** Secretary/Treasurer, International College of Surgeons, Michigan Division, Chairman, Department of Surgery, Sinai Hospital, Detroit, MI, Clinical Assistant Professor of Surgery, Wayne State University, Detroit, MI

#### **Guest Speakers**

David Fromm, M.D., F.A.C.S., Surgeon-in-Chief, Detroit Medical Center, Chief of Surgery, Harper Hospital, Penberthy Professor and Chairman, Wayne State University, Detroit, MI, LECTURE: Retroperitoneal Fat Necrosis Due to Pancreatitis.

Norman Thompson, M.D., F.A.C.S., Chief, Division of Endocrine Surgery, Professor of Surgery, University of Michigan, Ann Arbor, MI, LECTURE: Pancreatic Islet Cell Tumors - Endocrine and Surgical Implications: Diagnosis & Treatment.

Adrian Kantrowitz, M.D., F.A.C.S., Professor of Surgery, Wayne State University, Dept. of Cardiovascular Surgery, Sinai Hospital, Detroit, MI, LECTURE: Mechanical Left Ventricular Assistance.

Oliver Beahrs, M.D., F.A.C.S., Professor of Surgery, Emeritus, Mayo Medical School, Rochester, MN, LECTURE: Surgical Disease of the Thyroid of the 90s. Jerry Hodak, WJBK, Channel 2, Southfield, MI, LECTURE: Medical Reporting in Television.

David Sutherland, M.D., Ph.D., Professor of Surgery, Director of Pancreas Transplant Program, University of Minnesota, Minneapolis, MN, LECTURE: Pancreatic Transplantation.

Alfred E. Chang, M.D., F.A.C.S., Professor of Surgery, Chief, Division of Surgical Oncology, University of Michigan, Ann Arbor, MI, LECTURE: Resectional Therapy of Liver Tumors.

Eduardo Phillips, M.D., F.A.C.S., LECTURE: Diagnosis and Treatment of Occult G.I. Bleed from Small Bowel.

Anthony Senagore, M.D., M.S.,F.A.C.S., Director of Research, Ferguson-Blodgett Digestive Disease Institute, Grand Rapids, MI, Associate Professor of Surgery.

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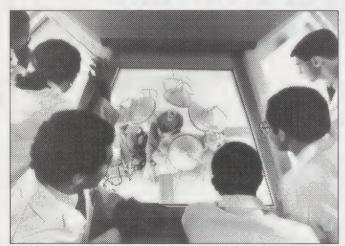
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## **MEETINGS**

#### **MSMS** Meetings

#### January

13, "The Masters Series," Cornerstones to Successful Health System Reform: Managed Care in Michigan: The New Architecture of Health Care Delivery. Embassy Suites Hotel, Southfield, MI. Contact: MSMS Office of Physician Education, (517) 3365784.

**19,** MSMS Board of Directors Meeting, MSMS headquarters, East Lansing. Contact William E. Madigan, Executive Director, at (517) 337-1351.

#### **February**

**25-26,** "The Masters Series," Cornerstones to Successful Health System Reform: POs/PHOs: From Cutting Edge to Reality. Ritz Carlton Hotel, Dearborn, Ml. Contact: MSMS Office of Physician Education at (517) 336-5784.

#### March

**9-10,** 1994 MSMS Maternal & Perinatal Health Conference, Collaboration for Prevention. Ritz Carlton Hotel, Dearborn, Ml. Contact: MSMS Office of Physician Education at (517) 3365784.

11, "The Masters Series," Cornerstones to Successful Health System Reform: Antitrust/Negotiations/Conflict Resolution Conference. Ritz Carlton Hotel, Dearborn, Ml. Contact: MSMS Office of Physician Education at (517) 336-5784.

**11-12,** MSMS 3rd Annual Joint Section Meeting. Ritz Carlton Hotel, Dearborn, MI. Contact: Judy Marr, Manager, MSMS Department of Communications & Professional Relations, (517) 336-5744.

**23,** MSMS Board of Directors Meeting. MSMS headquarters, East Lansing, MI. Contact: William E. Madigan, Executive Director, at (517) 337-1351.

#### April

**20,** MSMS 1994 Capitol Checkup. Michigan Historical Museum & Library, Lansing, MI. Contact: Greg Aronin, Chief, Legislative Affairs, MSMS Department of Government Relations, at (517) 336-739.

**21,** "The Masters Series," Cornerstones to Successful Health System Reform:

Control Your Future, Control Your Data: Physician Data Requirements. Embassy Suites Hotel, Southfield, MI. Contact: MSMS Office of Physician Education at (517) 336-5784.

#### May

**6-8,** MSMS House of Delegates Meeting. Amway Grand Plaza, Grand Rapids, Ml. Contact: Donna Farougi, MSMS Executive Offices, at (517) 336-5735.

**6 & 8,** MSMS Board of Directors Meeting. Amway Grand Plaza, Grand Rapids, MI. Contact: William E. Madigan, Executive Director, at (517) 337-1351.

#### Michigan Specialty Society Meetings

#### **February**

**9,** Michigan Specialty Society Presidents Meeting. MSMS headquarters, East Lansing, MI. Contact: David K. Fox at (517) 336-5731.

#### April

**7-8,** Michigan Medical Group Managers Association Spring Management Meeting. East Lansing. Contact: Caroline Kimmel at (517) 336-7587.

**16-17,** Michigan Society of Internal Medicine Spring Meeting. Southfield, Ml. Contact: Caroline Kimmel at (517) 336-7587.

**23,** Michigan Society of Anesthesiologists Annual Meeting. Ritz Carlton Hotel, Dearborn, MI. Contact: Caroline Kimmel at (517) 336-7587.

#### May

**2-4,** Michigan State Medical Society Alliance House of Delegates. Ritz Carlton Hotel, Dearborn, MI. Contact: Dawn Reha at (517) 336-7589.

**3-6,** Michigan Society for Respiratory Care Annual Scientific Symposium. Amway Grand Plaza, Grand Rapids, MI. Contact: Caroline Kimmel at (517) 336-7587.

**5-6,** Michigan Chapter, American College of Surgeons Coller Day Competition. Ritz Carlton Hotel, Dearborn, Ml. Contact: Vi Heins at (517) 336-7586.

#### **AMA Meetings**

#### **February**

**11-13,** Leadership Conference. San Francisco, California. Contact: William E. Madigan, MSMS Executive Director, at (517) 337-1351.

#### March

**11-13,** National Conference on Family Violence. Hyatt Regency on Capitol Hill, Washington, D.C. Contact: Judy Marr, Manager, MSMS Department of Communications & Professional Relations, at (517) 336-5744.

#### June

**12-16,** AMA House of Delegates Meeting. Chicago, IL. Contact: Judy Marr, Manager, MSMS Department of Communications & Professional Relations, at (517) 336-5744.



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Michigan Medicine each month carries a list of opportunities in Nichigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

#### January

**21-22, EGD (Gastroscopy) Location:** Ashman Court Hotel, Midland, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-4622492. Approved for: 12 hours Category I Credit.

24-26, Fiberoptics Workshops for

the Difficult Airway. Location: Disney's Yacht Club Resort, Lake Buena Vista, Florida. sponsor: University of Michigan Medical School, Department of Anesthesiology. Contact: Melody Curry, Registrar, Towsley Center for Continuing Medical Education, P.O. Box 1157, Ann Arbor, NI 48106-1157. Approved for: 16 hours Category I Credit.

**27-28,** Colposcopy for the Primary Care Physician. Location: Ashman Court Hotel, Midland, Michigan. sponsor: The National Procedures Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 12.25 hours of Category I Credit.

**29,** LEEP/LETZ/LOOP. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. **Contact:** Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-4622492. Approved for: 6.25 hours on Category I Credit.

#### **February**

**2,** The International College of Surgeons - Michigan Division, Annual Scientific Session. Location: Sinai Hospital, Detroit, Michigan. Sponsor: International College on Surgeons, Michigan Division. Contact: Sheri Waldman, 313-493-5279. Approved for: 6 hours Category I Credit.

**4-5,** Sclerotherapy. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-4622492. Approved for: 11.25 hours of Category I Credit.

**6-11,** The 18th Annual Midwinter Family Practice. Location: Boyne Highlands Inn, Harbor Springs, Michigan. **Sponsor:** University of Michigan Medical School, Department of Family Practice, and the Michigan Academy of Family Physicians. **Contact:** Towsley

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#### **CATEGORY I COURSES**

Continued from page 55

Center for Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. Approvea for: 20 hours of Category I Credit.

10-13, Advances and Controversies in Head and Neck Oncology. Location: South Seas Plantation, Captiva Island, Florida. Sponsor: University of Michigan Medical School, Department of Otolaryngology. Contact: Towsley Center for Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, NI 48106-1157, (313) 764-1400. Approved for: 12 hours Category I Credit.

11-12, Stress EKG. Location:
Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallman, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-4622492. Approved for: 12 hours of Category I Credit.

25-26, Colonoscopy/Common Ano-

rectal Disorders/Hemorrhoid Treatment. Looation: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Linda Hallmann, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. Approved for: 12.25 hours of Category I Credit.

**25-26,** Advanced Trauma Life Support. Location: Towsley Center, Ann Arbor, Michigan. Sponsors: The Nichigan Committee on Trauma, The American College of Surgeons and The University of Nichigan Medical School. Contact: Steve Cruise, Towsley Center for Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. Approved for: 18 hours Category I Credit.

**27,** 2nd Annual Midwinter Cardiovascular Update. Location: Boyne Highlands Inn, Harbor Springs, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Towsley Center for Continuing Medical Education, P.O. Box

1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 20 hours Category I Credit.

**27, Practical Aspects of Radiology and Imaging. Location:** Marriott's Camelback Inn Resort, Golf Club & Spa, Scottsdale, Arizona. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Towsley Center for Continuing Medical Education, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 20.5 hours Category I Credit.

#### March

**22-23,** Fiberoptics Workshops for the Difficult Airway. Sponsor: University of Michigan Medical School, Department of Anesthesiology. **Location:** Red Lion's La Posada Resort, Scottsdale, Arizona. **Contact:** Towsely Center for Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, NI 48106-1157, (313) 763-1400. **Approved for:** 16 hours Category I Credit.

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Continued from page 57

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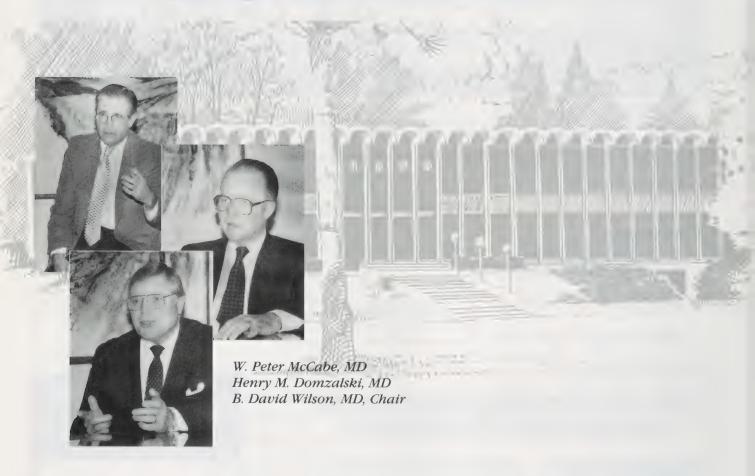




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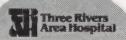
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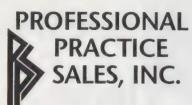
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| Binson's Hosp. Equipment    | 59     |
| Blue Cross/Blue Shield      | 31     |
| Bristol Myers               | BC, BC |
| Cellular One                | 49     |
| Comerica                    | 22     |
| Comp Health                 | 58     |
| Critical Care America       | 40     |
| Curare                      | 61     |
| Harper Associates           | 61     |
| Harvey Lexus                | 52     |
| Henry Ford Health Systems   | 58     |
| Joe Hickey                  | 62     |
| Kemper                      | 53     |
| Medical Billing Corp        | 15     |
| Medical Billing Service     |        |
| Metpath of MI               | 44     |
| MI Cap Medical Center       |        |
| MPMLC                       |        |
| MSMS Group Insurance Trust  |        |
| Mt. Clemens Hospital        | 51     |
| North Memorial              | 62     |
| Palisades Pharm             | 25     |
| PC Medical                  | 63     |
| Physician Service Group     | 1      |
| Physician Source & Search   | 59     |
| Physicians Leasing          |        |
| PICOM                       | IFC    |
| The PM Group                | 4      |
| Premier                     | 63     |
| Professional Practice Sales | 63     |
| Randolph                    | 62     |
| Rehab Institute             |        |
| Select Communications       | 16     |
| Sinai Hospital              |        |
| Sisters of St. Joe          |        |
| St. Luke's                  |        |
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### PRESIDENT'S PAGE

### **Health Security Act of 1993** (Details!—Details?—Details!)

By Gilbert B. Bluhm, MD

y mid-October of this year, rumor was strong that the Clinton Administration was struggling to be more explicit about its plan for health system reform, especially its funding. Actuarial projections for health use and cost have been chronically underfunded. To the drafters' credit, another look and delay before presenting the Health Security Act of

1993 to Congress seemed worthwhile. Meanwhile. the AMA decided to withhold significant criticism until the "details" of the plan were before Congress.

Well, we now have details...all 1,342 pages of them! The perspective on this prolific document can be characterized by noting that the Reagan Economic Reform contained 432

pages, the Medicare Act 32 pages and the Constitution of the United States 3 1/2 pages. The scribes for the mammoth Health Security Act of 1993 failed to heed the famous quote of Joseph Pulitzer: "Put it before them briefly so they will read it, clearly so they will appreciate it, picturesquely so they will remember it, and above all, accurately so they will be guided by its light."

AMA Executive Vice President James Todd, MD, commented recently that President Clinton should realize after his experience with the Federal Budget and Economic Recovery Plan that "Whatever Clinton proposes, Congress disposes!" There will be numerous congressional hearings. The most recent count already exceeds 150. There are 11 House of Representative and seven Senate committees and an additional 36 congressional subcommittees that plan to review



The perspective on this prolific document can be characterized by noting that the Reagan Economic Reform contained 432 pages, the Medicare Act 32 pages and the Constitution of the United States 3 1/2 pages.

the "details" of the Health Security Act of 1993. As Senator Bob Dole commented on the day the Act was presented to Congress, "It's time now for a second opinion."

It was not comfortable to see that about 1.000 pages of the Health Security Act detail and identify the role which is to be played by federal and state agencies in the implementation of President

> Clinton's concept of security, simplicity, savings, quality, choice and responsibility. Add in the control of the National Health Board which is to be appointed by the President, and which is to consist of federal employees, and it is little wonder citizens and physicians alike are worried. Where will be found the seven "Solomons" for health care? And, if appointed, will

they only set guidelines or more likely over-regulate? Their duties include defining a "one-for-all" benefit package, setting its price, guiding NIH research on clinical outcome, and collecting funds and restricting the "how, where and numbers" for graduate medical education.

I'm not ready for government to make me trade in my medical bag for a pocket calculator!

It is now time physicians begin the real debate and proceed to "draw a line in the sand" because the "USS" Health Security Act has been beached. Other "lines" to be drawn still include true national medical liability reform, antitrust relief for physicians, individual as well as employer requirements, real choices for the citizens as well as physicians, and meaningful education on healthy lifestyles. 

It's time for physician action!

#### PRAVACHOL® (Pravastatin Sodium Tablets) CONTRAINDICATIONS

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atheroscierosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since IMIG-COA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal farm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the hazards. If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

patient apprised of the potential nazard to the lettus.

WARNINGS
Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually appropriate athough worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in

atmough wondowine experience indicates that allorexial, wearness, allor of adult interplant paint may also be present rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. As with other lipid-lowering agents, livery six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals.) Special attention should be given to patients who develop increased transamines levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals, if increases in AST and ALT equal or exceed three times the upper limit of normal and persistence of confirmance the properties of normal and persistence of confirmance the subsequence of the properties of continuous.

trequent intervals. If increases in AS1 and ALI equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminortransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy. Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history liver disease or phany alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacolokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and litrated to the desired therapsource information.

patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgis has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creating phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.15%). Myopathy should be considered in any patient with diffuse myalgis, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomynolysia, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrohyte disorders; or uncontrolled epilepsy.

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, employed in the development of the properties of the province of the province

continued. The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.

PRECAUTIONS General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS).

This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin. Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

inhibitors are less effective because the patients lack functional LDL receptors.

Renal insufficiency: A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3a-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean ALC values and infi-life (tr2) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particulativi if accompanied by malaise or five.

weakness, particularly if accompanied by malaise or fever.

Drug interactions: Immunosuppressive Drugs, Gemfibrozii, Niacin (Nicotinic Acid), Erythromycin: See WARN-INGS: Skeletal Muscle.

INASC: oxideratin muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Chrome P490 system will occur.

Cholestyramine/Colestypoir. Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before codestipol and a standard meal, there was no clinically significant decrease in bia-availability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but bloavailability peraireters at steady state for pravastant placent configuration, when for caterious Pravastant placent configuration, when for caterious Pravastant in Judical control produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after days of concomitant therapy). However, bleeding and extreme protongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given with cimetidine compared to when administered with antiacid.

Digown: In a crossover that involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin ended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not aftered.

Gerniflorozii: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gerniforozii, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, here was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, here was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, here was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, incoming addition of the province of pravastatin and gerniforozii is generally not recommended.

In interaction studies with aspirin, antacids [1 h

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced (p<0.004) after 16 weeks of treatment with 40 mg pravastatin. However, the percentage of patients showing a >50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., lectoonazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CMS Toxicity: CNS vascular lesions, characterized by perviascular hemorrhage and edema and mononuclear cell

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell

infiltration of perivascular spaces, were seen in dogs treated with prayastatin at a dose of 25 mg/kg/day, a dose

infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the higher recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochiear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In 2 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg dody weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose (p<0.01). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weighs, sicher who for the place that these man of the place that the serum drug levels were only 6 to 10 times higher than those measured in humans onen 40 mg.

nignest dose (p<0.01). Atmough rats were given up to 125 times the human dose (HU) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls (p<0.05). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 31 times higher than the mean human serum drug levels approximately 3, 15, and 31 times higher than the mean human serum drug occonentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males the incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a) gland of the eye of rodents) were significantly higher in high-dose mice than in controls. No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of Salmonella typhimunum or Escherichia coli; a forward mutation assay in L5178YTK + / - mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using Saccharomyces cerevisiae. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice. In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not several or a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenice spithellum) was observed in a subsequent fertility study with another in this class caused drug-related testiciual ratophy, de-Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.
Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter²). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAWACHOL, (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAWACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAWACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Uses: Safety and effectiveness in individuals less than 18 years old have not been established. Hence,

CONTRAINMENT (1995).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: General.) ADVERSE REACTIONS

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients. Adverse Clinical Events: All adverse Clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below, also shown are the exceptances of nationate in whom these medical exacts were helieset for the restricted to the drive.

percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

|                     | All Ever                 | nts %                | Events Attributed to Study Drug % |                      |  |
|---------------------|--------------------------|----------------------|-----------------------------------|----------------------|--|
| Body System/Event   | Pravastatin<br>(N = 900) | Placebo<br>(N = 411) | Pravastatin<br>(N = 900)          | Placebo<br>(N = 411) |  |
| Cardiovascular      |                          |                      |                                   |                      |  |
| Cardiac Chest Pain  | 4.0                      | 3.4                  | 0.1                               | 0.0                  |  |
| Dermatologic        |                          |                      |                                   |                      |  |
| Rash                | 4.0°                     | 1.1                  | 1.3                               | 0.9                  |  |
| Gastrointestinal    |                          |                      |                                   |                      |  |
| Nausea/Vomiting     | 7.3                      | 7.1                  | 2.9                               | 3.4                  |  |
| Diarrhea            | 6.2                      | 5.6                  | 2.0                               | 1.9                  |  |
| Abdominal Pain      | 5.4                      | 6.9                  | 2.0                               | 3.9                  |  |
| Constipation        | 4.0                      | 7.1                  | 2.4                               | 5.1                  |  |
| Flatulence          | 3.3                      | 3.6                  | 2.7                               | 3.4                  |  |
| Heartburn           | 2.9                      | 1.9                  | 2.0                               | 0.7                  |  |
| General             |                          |                      |                                   |                      |  |
| Fatigue             | 3.8                      | 3.4                  | 1.9                               | 1.0                  |  |
| Chest Pain          | 3.7                      | 1.9                  | 0.3                               | 0.2                  |  |
| Influenza           | 2.4*                     | 0.7                  | 0.0                               | 0.0                  |  |
| Musculoskeletal     |                          |                      |                                   |                      |  |
| Localized Pain      | 10.0                     | 9.0                  | 1.4                               | 1.5                  |  |
| Myalgia             | 2.7                      | 1.0                  | 0.6                               | 0.0                  |  |
| Nervous System      |                          |                      |                                   |                      |  |
| Headache            | 6.2                      | 3.9                  | 1.7*                              | 0.2                  |  |
| Dizziness           | 3.3                      | 3.2                  | 1.0                               | 0.5                  |  |
| Renal/Genitourinary |                          |                      |                                   |                      |  |
| Urinary Abnormality | 2.4                      | 2.9                  | 0.7                               | 1.2                  |  |
| Respiratory         |                          |                      |                                   |                      |  |
| Common Cold         | 7.0                      | 6.3                  | 0.0                               | 0.0                  |  |
| Rhinitis            | 4.0                      | 4.1                  | 0.1                               | 0.0                  |  |
| Cough               | 2.6                      | 1.7                  | 0.1                               | 0.0                  |  |

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The following effects have been reported with drugs in this class:

Skeletat: myopathy, ribabdomyolysis.

Newrological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular

neurological dysination of certain carian invest (including alteration or taste, impariment of extra-occurrence) incoment, facial paresis, fremor, vertigo, memory loss, paresthesia, peripheral neuropathy, p

liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been

Laboratory less Anhormatives: increases in serum transaminase (ALI, AST) values and DPK have been observed (see WARNINIGS). Transient, asymptomatic eosinophila has been reported. Eosinophil counts usually returned to normal deplete continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors. Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, collestipol, nicotinic acid, probucol and gemfibrozii. Preliminary data suggest that the addition of either probucol or gemfibrozii to therapy with lovastatin or pravastatin is not associated with greater reduction in LDL-cholestor than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or ligid-lowering doses of nicotinic acid. Conomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: Skeletal Muscle and PRECAUTIONS: Drug Interactions.)

ve been no reports of overdoses with pravastatin

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Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

PRAVACHOLO LIPID MANAG

NLM 00879808

## Effective lipid management doesn't have to be tough

- Improves key lipids significant reduction in LDL-C'
- Excellent safety profile
- Easy for patients once-daily dosing, well tolerated
- Usual dose: 20 mg once daily at bedtime, with or without food

## pravastatin sodium 20 mg tablets

PRAVACHOL is indicated as an adjunct to diet for the reduction of elevated total and LDL-cholesterol levels in patients with primary hypercholesterolemia (Types IIa and IIb) when the response to diet alone has not been adequate.

Active liver disease or unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of pravastatin sodium

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.



Bristol-Myers Squibb Company



